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UNIVERSITY OF ALBERTA

INSTRUCTOR'S PERCEPTIONS OF SUBJECTIVITY IN CLINICAL EVALUATION OF NURSING STUDENTS

BY

RUTH STEWART

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND
RESEARCH IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR
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IN
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EDMONTON, ALBERTA

SPRING 1991

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SUBMITTED BY RUTH STEWART

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF EDUCATION

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DATE: April 17, 1991

ABSTRACT

Presented in this study are the perceptions of nursing instructors regarding subjectivity in the process of clinical evaluation of nursing students. The purpose of this study was to explore what educators perceived influenced subjectivity in the clinical evaluation of nursing students, what student characteristics and behaviors influenced an instructor's subjectivity and what strategies instructors utilized when dealing with subjectivity and its influence.

This study explored the perceptions of eight nursing instructors. Each participant was interviewed twice. The semi-structured interviews were tape recorded and transcripts were made of the tapes. The transcripts were analyzed for themes.

The findings of the study indicate that instructors feel there are numerous factors which exert subjective influence upon the clinical evaluation process. These factors include instructor experiences and expectations, input from others, and a student's patient assignment. As well, student characteristics such as gender, ethnicity and age plus student behaviors such as self expression, caring and facial expressions were reported to affect subjectivity. All participants felt that as their awareness of subjectivity increased the influence of subjectivity decreased. Other strategies utilized by instructors in dealing with subjectivity

included verbal and written feedback to students, additional instructor input and student self evaluation. Generally, the participants indicated it is desirable to reduce the influence of subjectivity in evaluative judgements.

Many issues reported to influence an instructor's subjectivity were not within a student's control. Instructor's indicated they felt they had minimal formal educational preparation for clinical evaluation which contributed to a lack of confidence with the task. The participants expressed a sincere desire to develop fair and accurate clinical evaluations of their students.

In summary, the findings of the study indicate that subjectivity is both a complex and inevitable component of the clinical evaluation process of nursing students.

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CHAPTER I

INTRODUCTION TO THE STUDY

The evaluation of nursing students in the clinical setting has been the subject of discussion for many years. For business, industry and professional groups, assessment of work is called performance appraisal. Clinical evaluation in nursing education is the performance appraisal of a nursing student by an observing and assessing instructor.

The degree of difficulty in the process of either clinical evaluation or performance appraisal seems to be related to the amount of subjectivity and interpretation that the rater (evaluator) brings to the process. It is generally acknowledged that subjectivity is an acceptable component in performance appraisal; some authors accept this as inevitable (House,1977; Feldman, 1986; and Landy and Farr, 1987). However, many authors recognize that there may be ways and means to reduce the influence that a rater's subjectivity has upon performance appraisals (or evaluations), of a nursing student in the clinical setting.

Considering there are approximately 1,400 nursing students enrolled in the four nursing diploma schools in the city of Edmonton and approximately 2,800 nursing students enrolled in the 13 educational programs for nursing throughout the province of Alberta (Alberta Health, 1988) it seems logical that clinical evaluation and the problems it causes for instructors and students would have been studied long ago. The fact is that evaluation tools and instruments such as criterion referenced checklists and critical incident checklists have been developed over the years but the effects and causes of instructor subjectivity seem to have escaped research. As Landy and Farr (1987) conclude following an extensive review of studies dealing with performance rating, "Research in this area is long overdue. It is time to stop looking at the symptoms of bias in rating and begin examining potential causes (p.101)." Other writers simply acknowledge that subjectivity is inevitable and offer no suggestions on how to measure it or control it.

One of the goals of clinical evaluation is to avoid arbitrary biased measurement. A student's progress throughout a nursing program is usually dependent upon a satisfactory evaluation of clinical performance at the completion of each term. The evaluation is determined by a nurse educator in most instances. These decisions can often be difficult for instructors since they must assess behaviors which often involve more than objective data. Many actions and behaviors involved in the nursing care of patients by a student are difficult to objectively define or describe due to their complex nature. The interpretation of observations of a nursing student by a nursing instructor can easily, without malice, include bias and thus become subjective. The human interaction between student and patient , as well as between student and instructor that occurs in the clinical environment is difficult to predict or measure. Each situation is unique and seldom can an instructor control the events that occur in the clinical setting. Clinical instructors must evaluate each student according to the course objectives utilizing the variety of experiences each student has encountered. Due to these circumstances, interpretation of a student's performance and the course objectives is ongoing.

In this study the perceptions of nursing instructors regarding subjectivity in the clinical evaluation process was the focus. Most instructors involved in clinical teaching, supervising, and evaluating nursing students, seek to make their assessments of students as fair and objective as possible. Insight into the practice of clinical evaluations could result if it could be discovered how instructors feel they are influenced by subjectivity and how they have dealt with these problems. As there seems to be an adequate number of tools and devices which can be used during clinical evaluation; the focus of this study is thus on subjectivity during clinical evaluation.

Statement of the Problem

The purpose of this exploratory study was to discover the perceptions of nursing instructors regarding subjectivity in the process of clinical evaluation of nursing students. The process of clinical evaluation of nursing students has posed problems for instructors for decades, especially in the realm of subjectivity. There is minimal research specifically addressing the difficulties encountered by educators while evaluating nursing students in a clinical setting. Some researchers over the years have suggested tools and instruments that might decrease the difficulty in recording student's performance and behaviors (McCaffery, 1978; Stainton, 1983; and Dunn, 1986). Although these may increase accuracy of the performance appraisal, these tools do not address the human interaction area of subjectivity.

The scope and effect of subjectivity on clinical evaluation is undefined in the available literature. The degree to which evaluative judgements are influenced by subjectivity was not found reported during this literature review. The literature does indicate that performance evaluators acknowledge the existence of subjectivity but researchers have not described to what extent subjectivity influences evaluative decisions. Granted, whenever people are involved in judgements and decisions, there will be a degree of subjectivity. However, when the future of a student is determined by the evaluation of one instructor, the instructor should be aware to what extent his/her decisions are subjective and strive to be as objective as possible.

Several writers have discussed ways and means that have been shown to increase rater accuracy. Landy and Farr (1987) note that "rater training has generally been shown to be effective in reducing rating errors, especially if the training is extensive and allows for rater practice" (p. 91). Wood (1985), in a study examining instructor concerns regarding evaluation, was interested in the lack of educational preparation by instructors for the task of performance evaluation. Gentile and Stevens-Haslinger (1983) emphasize that an instructor evaluates from his/her knowledge and expertise. They suggest that an instructor can only evaluate what he/she knows, and thus argue that thorough preparation of instructors is essential.

Although Kirkpatrick (1986) indicates that using two or more expert raters will increase the evaluation accuracy, this is neither done, practical or even ethical when evaluating students in the clinical environment with real patients. Landy and Zedeck (1983) suggest that that performance appraisal effectiveness may improve when observation and recording is done by one "evaluator" and the actual evaluation is done by an independent evaluator rather than having only one person observe, record, and evaluate. This concept is occasionally utilized when another instructor is consulted for an opinion based on the clinical instructor's observations, but generally, using more than one evaluator for assessment is not done.

This study did not attempt to measure subjectivity. The focus of this research study was to discover what nursing instructors perceived as subjectivity, the influence of subjectivity on clinical evaluation of nursing students, and what strategies instructors utilized when dealing with subjectivity and its influence.

Research Questions

The specific questions that this study addressed were:

1. What part does subjectivity play in the clinical evaluation of nursing students?
2. What characteristics and behaviors of nursing students do instructors perceive as influencing factors on their subjectivity in the clinical evaluation process?
3. How do instructors deal with subjectivity in clinical evaluation of nursing students?

These questions served to define the limits of the study.

Significance of the Study

This study has both a theoretical and practical significance. The results should be of interest to those instructors who are involved in the process of evaluating nursing students in a clinical setting. These educators work frequently with students in a clinical setting and are required to observe, teach and evaluate each student's performance. Evaluative judgements regarding observations of performance are often difficult. If the evaluator is informed and aware of subjectivity and how it influences judgements the evaluative process could be less difficult.

This study may also be of interest to those who develop educational programs and continuing education programs for nursing educators. The perceptions of the instructors in the study could encourage curriculum planners to incorporate related research regarding subjectivity and it's influence on clinical evaluation into clinical teaching courses. This could result in improved preparation for nursing educators.

In a practical sense, the results of the study may assist nurses who are planning to enter the field of nursing education in requesting educational courses which would be beneficial in clinical teaching, specifically clinical evaluation. As the literature indicates, many people feel that subjectivity is inevitable and thus they do not strive to understand it or reduce it. With increased research regarding subjectivity as it pertains to nursing education, educators may become more alert to judgement errors made due to their subjectivity and their biases. Also, those who are currently working as clinical instructors may gain some insights into their evaluative practices and biases by acknowledging the perceptions of the instructors as reported in the study.

Since there seems to be a lack of literature discussing subjectivity in the clinical evaluation process and its effects, this research study will contribute to the literature on clinical evaluation in nursing education. The clinical evaluation that a student receives from an instructor should be factual and accurate. It is hoped that this study will assist nurse educators to increase their awareness of subjectivity and that the results will assist them in controlling the influence subjectivity has upon their clinical evaluations. As well, it may indicate issues or topics from which future educational programs and/or studies might develop. The need for appropriate preparation for nurse educators was cited by Woods (1985) following her study of nursing instructors. The need for more research regarding the process of clinical nursing evaluation seems to be evident from the sparcity of literature available. Since this is a descriptive study with an exploratory nature it should be able to " shed new light upon the phenomenon" (Merriam and Simpson, 1984, p. 63).

Definitions of Terms

Certain terms which have special meaning within the context of this particular research study require a common understanding. For purposes of this study, the following terms are used.

Clinical evaluation: the assessment by a nursing instructor of a nursing student's performance while in a clinical setting. A type of performance appraisal.

Clinical rotation/posting: a term equivalent to clinical course.

Clinical setting: the actual hospital environment where a nursing student demonstrates clinical skills and abilities.

Nursing instructor: the immediate teacher/supervisor of nursing students whose responsibility it is to conduct a clinical evaluation for each nursing student during the current course.

Performance appraisal: the assessment by another person/persons of an individual's performance based upon objectives or expectations of performance/achievement.

Ratee: the person who is being assessed/evaluated during the performance appraisal/clinical evaluation. In this study the ratee is a nursing student.

Rater: the person who assesses/evaluates the subject of the clinical evaluation/performance appraisal. In this study the rater is a nursing instructor.

Subjectivity: involves thinking and/or formulation of a judgement incorporating nonobjective factors such as personal opinion,values, preferences or idiosyncrasies.

The terms clinical evaluation and performance appraisal originate from different settings but for the purposes of this study are interchangeable.

Outline of the Thesis

Chapter 1 of this thesis provides the introduction, statement of the problem for the study, research questions, significance of the study , and the definition of terms. Chapter II consists of a review of the literature relevant to the study. Chapter III discusses the research methods and procedures for the study. The research design, participants, method of data collection and analysis, limitations and delimitations of the study are presented in this chapter. The discussion of the findings of the first interviews with the participants is presented in Chapter IV arranged according to the three research questions. Chapter V is the discussion of the findings from the second interviews with each participant in the study. The summary, conclusions and recommendations are in Chapter VI. References and appendices appear after the sixth chapter.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The actual topic of subjectivity in clinical evaluation was not found during this review of the literature. The search for information had to be undertaken under other related titles and often in disciplines other than nursing or education. The following literature review is divided into several categories related to subjectivity in clinical performance evaluation and its many components.

Performance Appraisal - Characteristics of Raters

Landy and Farr (1987) conducted a comprehensive review of several articles dealing with various aspects of performance ratings. They found that although it would be desirable for complete performance appraisal to include a combination of objective, personnel, and judgmental views, in the practical sense it would be "difficult to obtain objective indices of performance for many job titles" (p.72).

Several characteristics of raters have been studied (Landy and Farr, 1987; Kirkpatrick, 1986; Mitchell, 1983 ; Woolley, 1977) with inconclusive results but one common finding was "rater experience appears to positively affect the quality of performance rating" (Landy and Farr, 1987, p. 78). Landy and Farr

(1987) conclude that relevant interaction between the ratee-rater is a factor in the evaluation process and that it " may be that different types of raters have different perspectives on performance that influence their ratings"(p. 78). This review of the literature indicates that these writers find it acceptable that there has been little effort towards developing non- objective evaluation. This seem unacceptable to this writer.

Potential Areas for Evaluation Error

During the review of the literature it was found that writers discussed several potential areas for evaluation error. Ratee error can benefit the ratee, as in halo error; or the error can be detrimental to the ratee as in the horn error. Human judgement, subjectivity, attribution theory, and categorization of observation are potential areas of error that are reviewed in the following discussion of evaluation error.

Feldman (1986) discussed what he felt was the inevitable halo error in performance evaluations. He stated that whenever cognitive processes are involved there will be biased judgements. Solutions to these problems are not easy but his major suggestions are that " supervisors possess the necessary expertise and have ample contact time with the ratee to be fully aware of their behaviors" (p. 175). Feldman also recommends that training programs and rating forms for a supervisor would be beneficial. He states that there is a need for performance evaluation to be recognized as a complex process that is influenced by behavior, ability, social and cognitive factors. Several studies are cited by him which studied various aspects of evaluation which have resulted in biased judgements. Feldman states there has not been sufficient research to date in this field and he calls for more research to be done.

While discussing personality and stereotyping, associated with performance appraisal, Sherman (1979) presents the idea that "halo effect leads to an artificially consistent picture of people, with any given assessment being uniformly good or uniformly bad" (p.122). He discusses the effect that referral information has on subsequent evaluators and concludes that regardless of how information is received, formally or through hearsay, it will influence the evaluator.

Kirkpatrick (1986) states that input from others in a position to evaluate the ratee should increase the fairness of an appraisal. This could reduce the halo effect (positive opinion) and the horn effect (negative opinion) of the evaluation. This idea, although it may be very valuable, is unreasonable in nursing education due to fact that students are caring for real patients who have the right to privacy and confidentiality. Having extra observers present to evaluate a student's performance could pose ethical problems. In the nursing clinical setting it is difficult for several people to evaluate a student's performance at the same time due to the required privacy of the patient. However, input could be received from nursing staff regarding student interpersonal relationships and their cooperation and contribution to aspects of nursing function from other staff members. This may or may not reduce biases in the evaluation depending on the motivation of the informing person.

It is common practice in nursing schools to inform all students of the expected level of performance through the use of a course outline or syllabus. Student performance appraisal is based on these objectives received at the commencement of the course. Instructors then conduct student evaluations guided by defined and specific objectives. However the instructor is still required to make judgements based upon his/her "observations", thus incorporating a subjective component. Several writers indicate that if an instructor is knowledgeable regarding the evaluative process, the margin of error in their judgements may be reduced (Feldman, 1986; Schneier et al., 1986; Wood, 1985; Woolley, 1977).

Schneier, Beatty, and Baird (1986) discuss some reasons why performance appraisals fail. They illustrate these reasons in a chart demonstrating problems in the process, symptoms of the problem as well as clues to solve the problem. (See Figure 1). The more complex is the task to be evaluated, the more likely there will be an error. Also, appraisal does require judgements and so cannot be expected to be totally objective. "No matter how conscientious and well-meaning a rater may be, human judgement is subjective" (p. 39).

Figure 1 :

PROBLEMS in the PROCESS of PERFORMANCE APPRAISAL

FIGURE DELETED DUE TO COPYRIGHT RESTRICTIONS

Source : Schneier, C. E., Beatty, R. W., & Baird, L.S. (1986). How to construct a successful performance appraisal system. Training and Development Journal, April, 38 - 42.

The aim of appraisal evaluations is to avoid arbitrary, biased measurement. Schneier, Beatty and Baird (1986) indicate an acceptance of inevitable bias which is more acceptable than previous writers cited because they require that there be some conscious efforts made to reduce bias. "People use their own conditioning, perspectives, values, expectations, philosophies, experiences, biases, prejudices and interpersonal style when making ratings" (p.39). It seems logical to believe that nursing instructors each have their own background and biases which may interact with their decision making process during clinical evaluation. The human element in evaluative judgements is seemingly ever present but the nursing student should not become a victim to these biases.

Forbes and Nelson (1979) found that clinical evaluation is one of the most challenging responsibilities assumed by nursing faculties. They state that "subjectivity still appears to be the foremost problem encountered by instructors. Subjectivity resides with the evaluator rather than with the evaluation tool itself" (p. 28). However, Schneier et al. (1986) also state that some measurement and judgement problems can be alleviated by using a variety of techniques. They feel that the key to successfully performance appraisal is to have objectives, observable behaviorally based criteria, and a competence based system. Another way to ensure success is to provide rater training and practise. Also, the rater must have communicated the standards upon which student performance will be judged.

Attribution theory is of interest when dealing with performance evaluation. Rice (1985) defines attribution theory as that "which deals with inferences people make as to why they and others act as they do" (p.36). The person "attributes" a cause to their behavior or performance to an outside cause, which the evaluator may not agree with or even be aware of. The evaluator at the same time may "attribute" the performance or behavior to a different cause, such as lack of ability or effort. This possible source of error further emphasizes the need for frequent discussion between instructor and student regarding the perception each has regarding situations.

Pervin (1984) suggests that another possible source of error is due to the fact the "all incoming stimuli are evaluated according to the relevance to the self" (p. 245). The way in which each person categorizes what they observe, according to Pervin, depends on its significance and impact on the observer. This leads to possible bias and inter-rater error. The practice of using evaluator teams in some fields would help reduce this error factor but in nursing it it not feasible for several instructors to observe nursing student with their patients in the clinical setting. This could be considered, however, with laboratory practice and skills testing.

Objectivity -Subjectivity

House (1977) discussed the terminology of objectivity and subjectivity. He states that "being objective means that the observation is factual, while being subjective means that the observation is biased in some way"(p. 40). It is important in the interest of accurate evaluation that the rater is interested in the performance free of distortions and biases.

Some writers discussed previously feel that it is impossible to be free of all biases. The arguments in that direction seem exceedingly strong; thus is seems important that the rater be at the least aware of a personal potential for bias and prejudice. Infante (1985) felt that to achieve any degree of objectivity the instructor had to be constantly cognizant of the expected outcomes and level of expected performance. She concluded that "varying interpretations are possible not only between and among faculty members teaching the same course, but by the same faculty member at different times and even in relation to different students" (p.153).

Woolley (1977) in her often cited article entitled "The Long and Tortured History of Clinical Evaluation", discussed a study by Haytor in which 31 nurse educators were shown three films of a nursing student giving nursing care to a patient. The students filmed gave various levels of care, (as rated by the researcher) from average, to satisfactory, to poor with several mistakes. The instructors were asked to grade the student in each film on a scale of A to F and give their reasons for the grade they had assigned. There was only 44 percent agreement between the instructors in the study and the researcher on the level of student performance. The reasons given by the instructors for their grade assignment often had little to do with the student performance. "Haytor described 19 of them as 'clearly subjective' and 25 as 'global and meaningless'" (p. 308). Woolley suggested that Haytor's study should be replicated but stated that she doubted it ever would be because of the reluctance of the nursing education profession to show the weaknesses they have in judging proficiency.

Variables in Performance Appraisal

In a comprehensive review, De Meuse (1987) examined 46 studies which directly investigated the effects of 3 classes of non-verbal variables (demographic cues, physical appearance and non-verbal behaviors) on performance appraisal and found that "the effects of non-verbal cues on person perception in general and performance appraisal in particular, are significant and varied" (p. 207). Of the 46 studies reviewed , 43 explored demographic cues over which the ratee has no control while only 3 studies dealt with appearance and behavior.

He developed a conceptual framework demonstrating the impact of non-verbal cues of the performance appraisal process. (See Figure 2). It is an interactive framework which is based on the hypothesis that 3 classes of non-verbal variables impact on the raters affective dimension and thus influence the performance appraisal of the ratee.

Figure 2 : A conceptual framework of the impact of non-verbal cues on the performance appraisal process.

FIGURE DELETED DUE TO COPYRIGHT RESTRICTIONS

Source : DeMeuse, K.P. (1987). A review of the effects of non-verbal cues on the performance appraisal process. Journal of Occupational Psychology, 60, 207 - 26.

DeMeuse described the conceptual framework as having two parameters. One paramenter is the "demographic, physical appearance, and non-verbal behavioral cues emmitted by the ratee" (p. 221), and the other parameter is "the extent of affective evaluation and perceived power the rater holds for the ratee" (p. 221). To be of value for other researchers these variables in this framework would require clearer definitions; however the direction of influence and categories are understandable and seemingly are applicable for future studies.

De Meuse (1987) also discusses how numerous non-verbal cues influence and bias the rater including such features as beards, smiles, eye movement, facial expressions, posture, race, age, sex, and attractiveness. One example cited is of a person with a tall erect posture, steady hands and feet leading to the perception of power while a person who is twitching, twisting and jiggling leads the observer to perceptions of powerlessness (p. 221). He concludes that there is a serious need for future research on the influence of non-verbal behavior and demographic cues and their effect on the performance appraisal process.

Performance Appraisal in Nursing Education

A frequently cited writer in nursing education regarding clinical evaluation is Woolley (1977). She has investigated numerous techniques, strategies and tools for evaluating students in the clinical environment and found them all to some degree inadequate or inappropriate. Wooley refers to when "trial and error" learning and students learning "through their mistakes" were recommended by some writers such as Infante (1975). This is considered inappropriate in modern nursing due to the ethical considerations for patient safety and rights; not to mention the the litigations that could arise. (p.309). Woolley (1977) stresses that laboratory and simulated experiences are valuable learning techniques and that these facilitate evaluation because variables can be more easily controlled than in the complex environment of the clinical agency. She also suggests that instructors just accept that subjective judgements in clinical evaluation are necessary; that while some items are measureable and that some aspects of nursing must be assess intuitively (p.314). She does not address the influence of any specific or general biases, how they could affect the judgements, or to what degree they are acceptable or not. Woolley does state that the problems of clinical evaluation rest largely with the inexperienced young instructor and that the more seasoned instructors have developed their own comfortable acceptable format and style. This avoidance of the real problem of subjectivity in the performance appraisal of nursing students seems unwise. Woolley is oft quoted and referred to but some of her conclusions should surely be challenged. To accept that over a number of years of experience every instructor will become comfortable with the subjectivity of clinical evaluation seems rather simplistic.

As discussed by Woolley (1977), numerous techniques have been developed to assist instructors with the task of performance evaluation. One such device is the performance checklist. McCaffery (1978) developed a checklist that is a criterion referenced tool listing each behavior required to successfully perform a task. McCaffrey (1978) found that improvement in performance of students using the tool was remarkable. Learners also expressed increased independence and self satisfaction when learning new skills. "Performance checklists are effective, efficient tools for teaching and evaluation. They provide the learner with self-paced learning, immediate feedback and reinforcement of performance" (McCaffrey,1978).

To develop such a list for every nursing skill that a student must learn would be an exhaustive task, however it is a very reliable tool for measuring performance. However, the volume of paper for documenting each necessary skill would be staggering. Also, some skills essential to nursing including verbal and non-verbal communication with patients would be difficult to assess by use of a checklist. The use of checklists would assist the instructor in making relatively unbiased judgments regarding necessary skills. The mechanics of completing and filing the numerous checklists would require planning.

Gennaro, Theilen, Chapman, Martin and Barnett (1982) developed a tool which they illustrated and described so that it could be utilized by any reader when completing a clinical evaluation. The evaluator, using the tool, would still require clearly defined objectives from which to evaluate. The tool strives for objectivity in that it only includes observable and measurable items and activities which may limit its scope of application in the clincial setting. These writers failed to address subjective concerns as noted by other writers (De Meuse, 1987; Schneier, 1986). Instructor experience, attributes or educational preparation also were not discussed as variables to the objectivity of a rater using this tool.

Sometimes in industry, a manager will simply avoid performance appraisals if they seem too time consuming or difficult (Schneier, Beatty, & Baird, 1986), but nursing students must receive an evaluation at the end of each clinical course prior to progression to their next course. Nursing instructors cannot avoid this task and so a more acceptable approach towards recognizing and reducing biases in the clinical evaluation process must be developed.

Clinical Grade Assessment

Writers have swayed to and fro on the issue of assigning, or not assigning, grades to clinical performance evaluations (Bondy, 1983; Cottrell, Cox, Kelsey, Ritchie, Rumph, Shannahan, !986; McCaffrey, 1978). The swing in either way has found support among instructors but the issue itself has not been resolved due to the changing nature of each educational institution's policies. Also, some scholarship granting agencies require specific grade point averages in their application process and will not provide awards based on a simple "satisfactory" grade. Infante (1985) states "there is no solution to the grading problem satisfactory to all concerned" (p. 150). She accepts that grading must be done but emphasizes that the behaviors and performance for each letter grade must be clearly delineated by the school faculty and shared with the students.

Gentile and Stevens-Haslinger (1983) recommend that a grading system of two or three passing grades be utilized. They state that "the fewer grading options, the fewer errors a teacher will make discriminating whether each student has reached the standard of mastery" (p.53). They emphasis that the use of the simpler pass-fail scheme does not provide sufficient incentive for students to work towards excellence. Students in this scheme may work only at a minimum level and settle for lowest pass possible. Each instructor works within the policies and system of the agency they are hired by. The instructor is the person who must decide if the student's performance meets the level of expected standards, exceeds it or fails to meet it. "It is a subjective decision, to be sure, but instructors are hired because they have the expertise to make such decisions" (Gentile and Stevens-Haslinger,1983, p.54). Instructors can only be expected to make evaluative decisions within their range of expertise. Until educators acknowledge that there must be a conscious effort made by instructors to recognize areas of bias and influence, it can never be said that all which could be done to reduce subjectivity of evaluation was in fact done, no matter what technique or tool is utilized.

Instructor Preparation

Wood (1985) discusses a questionnaire completed by 197 nursing instructors from six Canadian provinces who had attended continuing education classes on the topic of clinical evaluation. The group studied was very select and could not be considered to be a representative group of instructors in Canada. Although these instructors were interested enough in evaluation to attend the course of seven classes, 58% of the participants had no previous course work on the topic of clinical evaluation. Although they were all active instructors with adequate educational preparation for their position, only 42% stated that they had any formal course work in the area of clinical evaluation. These instructors stated that their major concern regarding evaluation were biases that could be involved due to the human nature of the evaluative process and the legal implications for their judgments on the student.

Karns and Schwab (1982) state that "content in teacher preparation is usually related to classroom teaching methods and procedures to document students clinical behaviors" (p.42). They found that even in master's nursing programs there was little concern given to the subject of teacher-student relationship in clinical teaching. Their research indicates that student learning improves when they perceive that their nursing instructor respects and has confidence in their abilities. However, some faculty in that study expressed the belief that "establishing a good relationship with students decreases a student's motivation and quality of performance" (p.42). These two opinions seem to contradict each other.

Lancaster (1985), noted that "generally people perform more effectively in an environment with minimal threat and punishment; individual responsibility should be encouraged, rewards based on results, and a climate of trust and open communication should prevail" (p.16). She continues to discuss how motivation can be fostered and developed but concludes that "creating such a climate requires an understanding of motivation, human nature, and the characteristics of an environment that inspires excellence" (p.16).

The previously quoted instructors in the Karns and Schwab study who felt that motivation was hindered by a good instructor-student relationship seem to be de-emphasing the concepts that Lancaster has emphasized. If they had more formal preparation for their instructor roles and responsibilities they possibly might not have held these feelings. Gentile and Stevens-Haslinger (1983) quote Moore (1968) as stating that "perhaps attempts to make the evaluation technique more objective are misdirected and more effort should be spent in making the teacher-observer better equipped to judge the quality of nursing care" (p.54). They emphasize that the instructor can only evaluate based on his/her own knowledge and expertise. It is inherent to the process that there will be variations between teachers as well as differences among students and that even when tools and standards are developed, there will remain some margins of error. Their comment "the observer will see only what she knows" (p.54) supports the need for proper and thorough preparation of instructors. The evaluator must know what is expected and what the standards are in order to evaluate if the student has met the requirements.

A variety of evaluative techniques is advocated by Morgan and Irby (1978). They report that no one single technique is adequate and that instructors must knowledgeably in selecting the most appropriate means of evaluation for their programs. They report that in one study regarding observer training, the percentage of agreement in evaluative decisions among four dental faculty members increased from 54 to 77 "following six seminars that emphasized their definition, meaning, measurement, and evaluation of each step of the procedure to be evaluated" (p.23). They state that their review of the literature at that time (1978), indicated that instructors needed greater expertise and training in observational skill to improve intra-rating reliability. The current literature still supports that belief Wood (1985) was concerned about the lack of preparation by instructors for the task of performance evaluation. Previously cited writers from the literature stated that one way to reduce error and bias in the judgments of performance appraisal is to have well trained evaluators (Landy & Farr, 1987; Kirkpatrick, 1986, Woolley, 1977). Wood acknowledges the evident lack of preparation of nursing instructors and concludes that "the educational accountability demands on the nursing instructors makes it imperative that such content be included in the basic preparation of nursing instructors" (p. 8). Therefore, Wood, with the faculty of Nursing at University of Western Ontario, developed a 26 week course entitled "Evaluation in Nursing Education" which included a section on clinical evaluation. Theoretical content, as well as practical field work comprise the course. Performance appraisal continues to require research to determine if formal preparation of instructors does in fact increase the accuracy and objectivity of clinical evaluation.

Legality of Clinical Evaluation

The issue of the legal necessity of accurate unbiased clinical evaluation by instructors is discussed by Fowler and Heater (1983). They agree that the subject of clinical evaluation is not new but there is concern in the area due to increasing appeals and litigations by students. The courts also have determined it is right to "hold a professional nursing student to the same level of clinical competence as a registered professional nurse" (p. 402). This claim has heightened interest in accuracy and subjectivity of clinical evaluation. The authors cite several cases in which the courts "upheld the right of educators to exercise judgment which is subjective and evaluative in assigning grades" (p. 402). Students should be provided with an appeal system to challenge instructors' decisions. They state the legal implication of clinical evaluations and the necessity that it be based on standards made available to the student but do not suggest any methods by which to achieve this goal. They do, however, encourage daily documentation and collaboration with a student regarding progress. Wood (1985) reiterates this need by stating that most successful appeals by students are won due to inadequate documentation by the instructor. Based on their review of several court cases involving student dismissal due to unsatisfactory performance. Neidringhaus and O'Driscoll (1983), suggest that "whatever the evidence and situation, relevant observations should be recorded and then shared with the student" (p.159). The sharing process affords the student an opportunity to discuss the observations and provide clarification. Documentation of these meetings should be kept with both the student and the instructor signing the records. They emphasize that accurate documentation is critical and that the student be informed and /or warned of any possible disciplinary actions.

Neidringhaus and O'Driscoll (1983) also state that "current court cases uphold the expertise of faculty for making decisions concerning a student's progress" (p.159). This is in agreement with the findings of Fowler and Heater (1983). The courts demonstrate confidence that educators are qualified to evaluate student performance. In contrast, the evident lack of preparation for these tasks, as suggested by previously cited writers, raises the question of "what indeed is the necessary expertise needed to evaluate student progress?" To date, as found in the literature reviewed, this has not been challenged in the courts.

Conclusion

The literature search regarding "subjectivity in clinical evaluation" was conducted through broad avenues. The topic is not a pure one. The research in this area is minimal. Most of the research is in related fields or similar areas. There is a general agreement in the various disciplines regarding subjectivity and the problems it poses, but few clearly state any real solutions to the problem. The writers who do suggest solutions present ideas that are difficult if not impossible to enact in nursing, such as video cameras and multiple team observers.

The literature reviewed, stresses the importance of accurate and fair evaluations, as well as the numerous possible causes for error. A few writers seriously address the importance of preserving the interpersonal aspects of teaching and evaluating while also maintaining objectivity in the evaluative phase of teaching. Most of the writers reviewed acknowledge the need for appropriate training for evaluators. Those with nursing education qualifications emphasis the lack of formal preparation for nursing instructors in their educational programs with regards to teaching and evaluating nursing students in the clinical setting.

Authors from non-nursing fields, such areas as business, dentistry and psychology repeatedly discuss the difficulty of developing evaluations on students or employees, encountered in the field or practical settings. Many of these difficulties are related to personality, motivation and observability. Nursing editors seem to be more vague and unwilling to admit that they have difficulties. Often these writers would discuss tools and devices for evaluation and avoid the personal aspects of the process. This could reflect a defensiveness of their weaknesses or it could be an honest omission. The topic of subjectivity in nursing education and evaluation seems to be almost not existent in nursing literature in recent years.

CHAPTER III

RESEARCH METHODS AND PROCEDURES

Introduction

This chapter provides details of the design and methodology of the study. The selection of the participants and a description of the participants is included. The process of data collection, the pilot study and data analysis conclude the discussion.

Design

This study is an exploratory study utilizing a qualitative method. Bogdan and Biklen (1982) discuss qualitative research as data collection which allows for description which is not readily adaptable to statistical analysis and data that are not numerical. "The written word is very important in the qualitative approach, both in recording data and disseminating the findings" (p. 28).

This style of research permits the use of various tactics. The descriptive method, according to Merriam and Simpson (1984), includes two advantages for a researcher. This includes its ease of use to produce data that are accurate and representative, as well its flexibility so that variables may be studied that indicate probable cause as well as "additional variables that may be discovered that shed new light upon the phenomenon" (p. 63).

Methodology

The research was conducted with instructors from three Edmonton diploma nursing programs between May and July 1989. There are a total of five nursing education programs in Edmonton, four at the diploma level and one at baccalaureate level. Three of the diploma programs are hospital based schools and one is community- college based. For this study three diploma programs are included. The fourth was not included because the researcher could not establish contact even after repeated attempts. The baccalaureate level program was excluded because of the difference in semester schedule from the diploma programs and shortness of its spring session.

Permission to recruit volunteers for this study was requested from the director or dean of the nursing schools in March 1989. Each director or dean was asked verbally in person or by phone for permission to contact their faculty for the study. Two of these requested a written letter of explanation. One dean directed the request to a faculty committee for approval. All three director/deans in the study agreed to have their faculty approached for inclusion in the study with the understanding that the names of the participants and their comments would not be made available to the programs or the director/dean.

Ninety-five instructors were sent an introductory letter through interoffice mail in April 1989 requesting voluntary participation in this study. The letter described the study, its purpose, and how to volunteer. The intention of the researcher to tape and later transcribe the interviews is explained in the introductory letter (see Appendix A). Included with the aforementioned letter was a form and stamped envelope with which to volunteer or request additional information regarding the study (see Appendix B). Assurances of anonymity and confidentiality were given to the participants that the researcher would use pseudonyms in tape transcriptions and would erase the tapes following completion of the study.

Two semi-structured interviews based on the three research questions were used to gather data. Written permission to tape the interviews was received at the time of the interviews from each participant (see Appendix C). The first interviews commenced on May 8, 1989 and the second set of interviews started on June 19, 1989. There was a minimum of five weeks between interviews for any participant. The interviews were arranged at the times convenient to the participant. Most of the interviews were held in the participant's offices at the end of their formal work day although a few interviews were early in the morning and some were held over lunch, at the participants' request. The interviews occurred throughout the work week, Monday to Friday. The first interviews were approximately one hour in length while the second interviews were generally slightly shorter.

Borg and Gall (1983) describe one advantage of the interview over other research techniques is that it allows for greater depth than other data collection methods as "it's principle advantage is its adaptability" (p.436). They further state that semi-structured interviews provide an acceptable level of objectivity while providing the researcher with the option to explore any answer for depth and clarification. Merriam and Simpson (1984) concur that the depth of information attainable from interviews is useful. Also, interviews allow the researcher to develop a rapport with the participant and gain the widest range of data possible. Unanticipated questions can develop during the interview which provide for additional information. Bogdan and Biklen (1982) state that by designing interviews on the lines of a conversation between two interested parties that the interviewer has a higher probability of "capturing what is in the minds of the subjects themselves (p.43). Cohen and Manion (1980) state that open-ended questions have a number of advantages including flexibility, allowing for probing, and allowing for unexpected answers (p. 297).

The instructors in the study answered interview questions based on their personal interpretation and direction, thus the answers to each question although similar in topic were diverse and varied.

Participants

The study was comprised of eight nursing instructors, seven female and one male, from three diploma nursing schools in Edmonton. Although demographic data were not collected regarding the participants, they appeared to range in age from the mid-twenties to the mid- forties. Their years of experience as nurse educators, as indicated from their interview comments, varied from several years of experience (six instructors) to one or two years experience (two instructors). All the participants expressed interest in the study and a concern for the influence subjectivity exerted on clinical evaluation.

It was anticipated that the study would consist of 6 to 9 participants. The information from this size of group would provide information to expand knowledge regarding the subject of instructor's perceptions of subjectivity in clinical evaluation although it could not be generalized to a large population.

Although 56 volunteer responses were returned to the researcher, only 27 educators met the criteria of working with a clinical group to be eligible for inclusion in the study group. Participants were selected for the study from the total number of letters received based on chance and mutual availability of the participants and the researcher. Although nine instructors were originally selected for the study, one was later omitted due to unavailability.

Data Collection

The objectives of the semi-structured interviews were to gather information relating to the research questions. The participating instructors were interviewed by the researcher twice. In the first interview they received a full explanation of the study. Their questions were answered regarding the study. Their ideas, thoughts and perceptions regarding subjectivity in the clinical evaluation process were solicited. At the end of the spring semester once the instructors had completed written evaluations of their students, the educators were interviewed a second time. During the second interview, each instructor was asked the same research questions as previously asked in the first interview. The openness of the questions and the interviews allowed the researcher to probe each response in order to gather more in-depth information and clarification.

The first interviews were conducted in May 1989 shortly after the instructor had met with the student group. The second interviews started in June 1989 after the instructor had completed at least one evaluation of the student's performance. Some of these evaluations were summative evaluations (the final evaluation of the semester); and some of the evaluations were formative (held at a midpoint of the semester) of the students performance in the clinical setting. The students receiving formative evaluations in June were to return in September to complete their clinical rotation. There was no attempt made to determine if the findings of the study were influenced by the variation of evaluation, either formative or summative.

Each interview was tape recorded for ease of transcription and data analysis. Transcripts of the interviews were typed by the researcher utilizing pseudonyms to protect the identity of the participants.

Pilot Study

The research questions and interview format were pilot tested with two nursing instructors from one school of nursing in Edmonton. Both educators had more than five years experience in nursing education. The time required for the each interview was approximately 60 to 90 minutes. Each educator was interviewed once. The interviews were tape recorded with the participant's permission and transcripts were made from the interviews using pseudonyms. After the interviews, some interview questions were deleted to avoid repetition and wording modifications were made to some questions to improve clarity.

Data Analysis

The analysis consisted of two types: ongoing and content for specific purposes. The data analysis is descriptive in nature. Although notes were written following each interview, the content analysis was used to explore themes after all the data were collected.

Ongoing analysis. A small amount of ongoing analysis did take place during the interview phase to ensure that appropriate data were being collected. The analysis at that time consisted of reviewing the research questions to maximize similar information retrieval from each participant. The emphasis placed on specific questions was dependent on the nature of responses received from the participants and the resulting follow-up exploration.

Analysis after data collection. After the interview data were collected, the tapes were transcribed with the use of a transcribing machine obtained through the University of Alberta Education Media services department. Each page of transcription was assigned a number based on the pseudonym of each participant and the interview number. The transcripts were analyzed for common themes: however, the single responses were noted even if they did not correlate to any of the common themes.

Codes were developed during the data analysis. These codes were arbitrarily assigned letter combinations and these were applied throughout the notes as the topics emerged. Some of the codes were changed to larger umbrella categories while others were split into smaller units as the process evolved. For example; initially one code developed was 'WD' representing "what instructor did ". As the analysis progressed, the data in the "WD' category were divided into several codes including self evaluation (SE), verbal feedback (VF), and patient assignment selection (PA). A card was made for each code during the reading of the transcripts. The page numbers of the transcribed notes that pertained to each subject were added to the cards. As the data analysis progressed, the code cards contained the page numbers in the transcripts where that subject could be found for reference. These cards facilitated the analysis since every category could be found and cross referenced for discussion.

The purpose of the content analysis was to identify significant and reoccurring themes which had relevance to the research questions. Similarities and differences in participant reactions were noted. These themes served as a means of reporting the findings.

Conclusions

This study was an exploratory study utilizing the qualitative method. Eight participants volunteered from three schools of nursing in Edmonton for the study and were each interviewed twice during spring session 1989. Semi-structured interviews were used to gather the data. The interviews were tape recorded and later transcribed for analysis. Confidentiality of the participants was maintained through use of pseudonyms during the transcribing of the tapes and the reporting of the findings.

CHAPTER IV

RESULTS AND ANALYSIS OF THE FIRST INTERVIEWS

In this chapter the findings of the first research interviews are discussed. This exploratory study was conducted using eight nursing educators in three diploma schools of nursing in Edmonton. Each of the participants was interviewed twice. The three research questions explored were:

1. What part does subjectivity play in the clinical evaluation of nursing students?
2. What characteristics and behaviors of nursing students do instructors perceive as influencing factors on their subjectivity in the clinical evaluation process?
3. How do instructors deal with subjectivity in clinical evaluation of nursing students?

The research findings are presented as they relate to each of the three research questions.

Research Question One

The first research question asked: What part does subjectivity play in the clinical evaluation of nursing students? Due to the exploratory nature of the study, the interviews were not intended to have participants discuss specific topics in depth but rather to share their ideas and experiences related to subjectivity in student appraisal. At times, probing occurred to achieve clarity of a topic. Not every participant commented on the same items.

The results of the interviews were coded by theme and frequency and are presented in tables in the chapter. Table 1 illustrates the general topics of the first research question as discussed by the eight participants. Eleven broad themes emerged and are discussed in the next section. The frequency of responses is noted in decreasing order.

Table 1

Factors Influencing Subjectivity in Clinical Evaluation

Topic	**Frequency N = 8**
Presence of Subjectivity	8
Interpretation of Objectives	6
Instructor Expectations	5
Instructor Experience	5
Interpretation of Objectives	5
Previous Evaluations	5
Input from Others	5
Observed Behavior	3
Timing of Evaluation	2
Patient Assignment	2
Non-clinical Responsibilities	1

Presence of Subjectivity. As can be seen in Table 1, all the participants stated they felt subjectivity was present in the process of evaluating nursing students in the clinical setting.

Only one participant felt that subjectivity was there to "some degree," while the remainder felt that clinical evaluation was largely a subjective process. Comments ranged from it was "my judgement based on my frame of reference," to " the human factor will always be there, " to "its inevitable and clinical evaluation can't help but be subjective." Overall, respondents felt it would be impossible to remove subjectivity from the process of clinical evaluation.

Most of the participants attempted to define subjectivity. The most common thread in these statements was that the subjectivity enters the process of student appraisal whenever interpretation begins. The term "objectivity" was also discussed. The common thread in the discussion of objectivity was that it is confined to observable behavior. Most stated that the data of evaluation are what's seen or heard or read, but that the interpretation or judging of the data is subjective.

Interpretation of Objectives. When instructors discussed objectives, they were referring to the use and interpretation of course objectives as used in clinical courses, practice and assessment. Five participants commenting on this topic stated course objectives had room for interpretation. The margin of interpretation of the objectives in their opinion seemed to vary. Only one respondent stated that the objectives she worked with were clearly stated. Because of these objectives she felt all the faculty were therefore close in their interpretation of behavior associated with them.

One educator indicated that although behavioral objectives were used in the course she taught, subjectivity was still present because each instructor still must decide on the level of achievement. Another participant also indicated that not every faculty member expected the same thing from the same objectives. Another felt instructor's interpreted objectives in their own way.

All interviewees indicated that there seemed very little that could be done to reduce the variance of interpretation of objectives. If the objectives were written specifically enough to reduce interpretation, they felt that there would be an unreasonable number of objectives required. One stated that to write all objectives in strict behavioral terms was a step back in time to procedural nursing. Interpersonal aspects of nursing could not be written specifically enough into behavioral objectives. Discussing objectives with peers seemed to raise the level of consensus of interpretation between co-workers but not all felt that this occurred regularly or was very effective.

Instructor Expectations. Five participants discussed instructor expectations as being a subjective component in clinical evaluation. Three stated that their expectations do change from time to time but the consensus was that expectations increase as the term progresses, even when written objectives remain the same in specific courses. That is, an instructor has different expectations of a student taking a clinical course in September than of a student later in the academic year.

Also, one instructor said she had different expectations of a student performing a skill for the "tenth time" than of a student doing the skill for the first time. Expectations do change from student to student, stated one participant, who added that there is a "bottom line of expectation for everyone." One participant, after talking to her peers, noted that some instructors seem to expect more detail than other instructors. While another instructor thought that her knowledge of a student's past experiences led her to have different expectations of that student than she had for other students.

All of the instructors interviewed exhibited a concern regarding their lack of uniformity of expectations. Several also indicated that this variance was a reality, and had come to accept it as a factor indicative of their individual human nature.

Instructor Experience. Five participants commented on the topic of instructor experience. All indicated that their own experiences as nurses and educators affected their subjectivity. In the process of evaluating a student in the clinical setting, one participant stated that her past experiences and knowledge played a part in her interpretation of a student's behavior and performance. Another participant believed that as she gained more experience, her evaluations of nursing students became less subjective.

One participant had previously held an administrative position which required her to evaluate staff nurses. Her experiences with staff evaluation had taught her to be very objective and to avoid subjective judgements unless she had extensive and verifiable evidence. As a result, she would seek observable repeated behaviors before considering the evidence worthy of documentation on evaluations. She said she was very careful as a result not to "prejudge" students.

Experiences with a specific ethic group had caused another instructor to develop the expectation that sometimes students from certain cultures had characteristics that posed some difficulties within their role as a nurse. Although this had not been demonstrated in all nursing students, this instructor felt it was an area of subjectivity that could not be overlooked.

One participant stated that her expectations depended on what clinical area the student had last been in. If the student had just completed a medical nursing rotation, then her expectations for performance were initially higher than if the student had just completed a mental health rotation. This was due to the type of performance and skills focused upon during each rotation.

Interpretation of Objectives. Five participants commented on the variable interpretation of objectives as being a component of clinical evaluation which could be influenced by subjectivity. Four participants who discussed this topic made references to "impressions" that instructors receive from students in the clinical area. One interviewee gave the example of a student observed doing incomplete work. This instructor said that the behavior observed could be interpreted as the student either being lazy or exhausted. The actions were descriptive and definite, but an instructor interpretation could vary and could be considerably different. Another participant felt that an instructor had to trust his or her "intuition" about what was happening and should accept that and work with it rather that deny it. One participant who commented "You don't see everything, and then you interpret what you've seen'" said it is this interpretation that is subjective. These participants agreed that interpretation by the instructor of what was observed played a significant role in the process of clinical evaluation.

Previous Evaluations. Four of the five instructors who chose to discuss the effect of their reading a student's previous evaluations on their assessments said they do not read the previous evaluations (at least until the midterm point of the term), because they each felt that the previous evaluations would increase their subjectivity. One instructor stated that if a student had come to her rotation with problems, that did not indicate that those problems would reoccur in this new rotation. This instructor also felt that if she were alerted to specific behavior or performance problems, she would perhaps be watching for them.

Another respondent noted "we have to trust what other instructors have said on the evaluations." She believed that a student would benefit from a new instructor knowing about identified strengths and weaknesses. And thus the student would get assistance early in the rotation, and not be waiting until a new assessment was developed. Another instructor presented a third opinion by saying that problems from one rotation might not be repeated. Therefore, "good" performance from a rotation might not be repeated either.

Only one instructor mentioned that evaluative comments are sometimes passed verbally among instructors formally at a faculty meeting, or casually in offices or at coffee breaks. Although she indicated she did not listen to casual comments, she felt it was difficult to forget or ignore them. She felt the more formal student reviews within faculty meetings provided valid, useable information.

Input from Others. Five participants chose to discuss who they received information from regarding a student's clinical performance. They stated that they received comments from nursing staff on clinical units and also said that they "considered the source" before acting on the information or giving it serious consideration.

There were two general patterns of thought which emerged from the comments regarding staff comments. One pattern was that staff will always tell an instructor the negative things about a student's performance and emphasize a student's weaknesses. The second theme from these educators regarding staff comments was that staff will sometimes attempt to protect the student and hide weaknesses from the instructor.

In the negative realm, two participants felt that some staff had personal motives for making their comments to an instructor, such as a need to belittle the learner due to their own inadequacies, or the feeling that nursing education should be tougher and more like the training of the past. A third educator said that sometimes staff members had different expectations of a student than did the instructor or than was communicated by the course objectives. For example, a staff member may focus directly on the work to be completed and value the speed with which the student might complete the tasks. However, the student may be slow completing the work, due to his or her focusing attention and effort on patient teaching or comfort. The difference in focus between the staff expectation and the student's focus may result in negative comments from that staff member that are not justified.

Regarding the second theme of protecting the student, staff may overcompensate for a student's slowness or omissions by saying "she did okay for a student." Several interviewees acknowledged that they asked staff for comments if that staff member had worked with the student or had observed a skill performed by the student. The instructors felt that these requests were justified because "you can't see everything."

(Nurse educators in clinical practice usually have 6 to 10 students in a group.)

Two participants stated that they asked patients about their impressions regarding the nursing student who had cared for them. One educator said she focused specifically on the student's communication skills. The other participant stated that she became quite concerned if the patient did not know who the nurse was and especially if they did not know that the nurse was in fact a nursing student. Nursing students are expected in all programs to identify themselves and their rank to their patients prior to commencing nursing care.

In most cases, the students were informed of information from other sources and asked for verification of the situation. Frequently the student's explanations were given preference over staff comments when the staff input had been negative.

4

Observed Behavior. The three educators who commented on the topic of observed performance included in their discussions their perceptions of only those behaviors and actions they actually saw a student perform. All stated that the process of observing students was a often a haphazard occurrence. Some days they would see their students a great deal and on other days they did not see them at all. One felt that a student could possibly go through a whole week without really being observed by an instructor.

One stated that, "What I actually observe or question them about is hit and miss; there's nothing objective about it." The objective part of the process, in one participant's opinion is what is observed or heard.

Timing of Evaluation. Two participants commented on the timing of clinical evaluation. Should a student be evaluated from day one of the rotation or not until the sixth day or sixth week? To complicate this issue was whether an instructor, who evaluated later in a rotation but had earlier either observed an error or had received a report about an undesirable behavior, could complete the assessment without being influenced by the earlier event.

Also discussed was whether everything seen or heard regarding the student's performance was eligible for evaluation consideration. For one instructor, evaluation started during the first introductory meeting.

Patient Assignment. Although only two participants elaborated on the topic of a student's patient assignment, they had several opinions and approaches to this as a problem which increases subjectivity in clinical evaluation. Both discussed the idea that students are given different assignments depending on whether an instructor perceives them as a "strong or weak" student. One said that the stronger student will get a more challenging assignment. This process eventually affects assessment evaluation because the student will have had a greater variation of experiences upon which the evaluation is based. So, "the stronger get stronger." On the other hand, to consistently challenge a student with a difficult assignment everyday can have the effect of overwhelming the student; this may not allow for growth of self confidence.

The other respondent noted that it was not always possible to provide challenging assignments because of the number and quality of patients on the clinical units and the number of students there at any time.

Non-clinical Responsibilities. Instructors' responsibilities when away from students was noted by one participant. This instructor felt that interruptions to time spent on the clinical unit with the students increased subjectivity because the instructor who is away is not available to assist students or to observe their performance. In some rotations the time that these interruptions take vary. This adds a subjective influence to the clinical evaluation process because students may get "pot luck" patient assignments and others who assess performance during the instructor's absence.

Analysis of Question One

Overall, instructors interviewed felt there was more subjectivity involved in the clinical evaluation of nursing students than what they believed was desirable. Most of the eight nurse educators said they had no control over many of the factors which contributed to subjectivity in the evaluation process.

The instructor's opinions varied as to what effect subjectivity exerts on evaluation. Student evaluation is often affected by many factors over which they have no control. All the topics discussed by the participants during the first interviews regarding question one were beyond the control of the student. For example, the factors such as instructor experience, instructor interpretation of objectives, timing of evaluation and patient assignment were all felt to influence subjectivity in clinical evaluation and so directly or indirectly affect a student's performance appraisal. A student could be penalized by an instructor during the clinical evaluation process if that educator was not aware of, or in control of, the extraneous influence exerted by these issues, which really have nothing do to with a student's actual ability or performance.

What is seen and heard by an instructor is highly subjective because there is no way in the clinical situation to ensure that each student is seen doing the same things. The ability to control the experiences and events on the nursing unit for the students seems impossible; thus an instructor sees only what is occurring at the time she is present. The instructor therefore has minimal control of these events.

This fact, that the opportunities observed are quite variable, increases subjectivity in the process of clinical evaluation of nursing students. Even when the instructor does in fact chose events to observe, unless each student is given the same opportunity under the same conditions, subjectivity is present due to the selection.

There is discussion in the literature and in the practice of nursing education about the "fairness" of evaluating a student before allowing time for learning to have taken place. The participants in this study commented on their perceptions regarding conflict within the role of an instructor due to the responsibility to teach and the responsibility to assess. Another source of conflict lies in the timing: that is, differentiation in the time for the student to learn and the time for the student to be tested. The decision regarding commencing the assessment phase of the instructor role seems to add subjectivity of clinical evaluation.

Research Question Two

The second question in the first interview asked instructors what characteristics and behaviors of nursing students influence subjectivity in the clinical evaluation process. The participants, in discussing their perceptions of subjectivity, cited many factors.

Table 2 lists the topics which evolved from this question in order of frequency. A discussion of how these affected subjectivity follows the table.

Self Expression. The characteristic of self expression includes nursing students who vocalize efficiently and/or frequently as well as those who are "quiet and shy." Also included in this trait are the "assertiveness qualities" of a student. Three participants stated they had negative biases

Table 2

Student Characteristics and Behaviors Affecting Subjectivity

Issue	Frequency N = 8
Self Expression	7
First Impressions	5
Personal Traits	5
Gender	5
Ethnicity	4
Personality	4
Anxiety	4
Caring	4
Age	4
Maturity	3
Physical Characteristics	3
Facial Expressions	3
Voice and Speech	3
Initiative and Interest	2
Responsibility	2

towards an overly vocal student. Such students were described as being "mouthy," attention seekers, and aggressive. An example of aggression was taking over a group discussion and/or dominating the discussion. One educator felt students might act this way to impress an instructor with their knowledge or linguistic skills. Another thought that a student who was excessively vocal might believe the degree of participation would result in a better grade. Respondents agreed they looked favorably upon group participation. Five educators commented they characterize the "quiet" student as answering only when questioned, offering few spontaneous comments, and acting passively or shyly. One participant reported this behavior did not concern her. The other instructors stated it was more difficult to assess and evaluate the abilities of quiet students. All participants reported that a quiet student could be performing at an acceptable level but their quietness did affect their performance assessment. Evaluation of quiet students required more thought and took more time on the part of the instructor than for other nursing students.

One participant stated she felt students with "low self confidence" sometimes come across as "quiet" because they do not spontaneously talk with, or approach, an instructor; and they will stop talking with their patient if an instructor comes into the room. These behaviors make if difficult for an instructor to evaluate their level of interaction and communication skills with their patients. In contrast, this participant felt that a confident student would initiate and maintain a conversation with a patient even when an instructor was present.

Two instructors reported that students who assert themselves by stating their opinions and ideas, explaining their actions and making attempts to act as patient advocates, were perceived as displaying more ability and confidence. Therefore, they were viewed favorably by these two participants.

First Impressions. Five participants chose to discuss their views of how first impressions have an impact on clinical evaluation. Three participants stated their first impressions of a student remain with them through the entire rotation. One felt that her first impressions of a student were 99% accurate and that she had learned over time "to go with them" as a reliable assessment factor. She stated that when she ignored a first impression almost always at a later date she would hear or discover that the impression had been true. Another instructor stated she began evaluating students right at the first meeting even before they started clinical practise in her rotation. This instructor felt that every contact with a student provided data that could not be ignored and so all of these pieces of data could influence the evaluation of a student.

Two participants felt the group dynamics during the first meeting with a new group of students influenced the impressions developed regarding each student present. One instructor said she was more interested in the first individual meeting with a student and the kind of communication at that time, rather than with the first group meeting.

Personal Traits . Five participants reported on specific personal traits of students that they felt increased their subjectivity in the process of clinical evaluation. The traits discussed were laziness, common sense, consistency, punctuality and tidiness.

Two instructors discussed their perceptions regarding laziness. One stated it was sometimes difficult to determine if a student was tired and therefore not participating in patient care or group discussions, or was lazy and choosing not to participate. This instructor felt the cause of the behavior was important, although the actions displayed by the student were similar. The second participant described the lazy student as one who would sit around as much as possible and avoid getting involved in any extra activity. Both felt a negative bias toward any student they identified as being lazy.

Only one participant stated she considered "common sense" as a positive attribute in nursing students. This instructor evaluated for it by determining how well a student sorted and applied appropriate theory knowledge to a clinical situation. The degree of consistency with which a student completed tasks, especially during the last half of the posting, was reported to influence the subjectivity of another educator.

A student who was late for clinical experience more than once caused one interviewee to make a conscious effort to watch for any pattern of late behavior with patient care, treatments and medication administration. The behavior of being late was felt by this instructor to increase her subjectivity.

One participant stated she valued tidiness and felt that she looked less favorably on the student who did not maintain tidiness throughout his/her activities as a nursing student. She felt an increased subjectivity in assessing a student who did not keep a tidy patient room, do neat charting or present a tidy appearance.

Gender. Five participants commented that the gender of a nursing student influenced subjectivity. The only male educator in the study stated, "we have higher expectations of our own sex" and thus thought he was more demanding of the male students than were female instructors. All the instructors stated that they had dealt with numerous male students who had ranged from poor to excellent neophyte nurses. One participant stated that she felt that she treated the males the same as the females; she had been educated with male nursing students and accepted male nurses as a normal part of nursing. None of the participants commented on female students but this is probably because most nursing students are female with the exception to the norm being the male student.

Ethnicity. Four participants discussed subjectivity in regards to race or ethnicity. All four mentioned Metis students. One stated the bias in regards to this group of students was to be lenient with them and to "go the extra mile to help them as a race as I see them as the most taken advantage of group." Another instructor described a situation where a Metis student had frequently submitted written assignments late and showed no remorse for the behavior. After this pattern was identified, the instructor, in discussion with other instructors, found that this was not the first Metis student in the program to have trouble with timelines. She felt in the future she probably would anticipate the behavior and would be more specific about absolute deadlines when dealing with a group of students that included a Metis student.

Three of the participants discussed their opinions of having a Negro or black student in their group. All three acknowledged that this was a characteristic that they had come to accept. The tendency to group or label students by skin color as a reason for their abilities was discussed by these nurse educators. One instructor acknowledged an awareness of hesitancy or suspicion for some of the values of the East Indian race and admitted to watching those students more carefully than other students.

Personality. In addition to physical characteristics, ethnicity, gender and maturity, some instructors reported personality influenced their rating of nursing students' performance. Four participants in this study said at one time or another in their careers as instructors they had encountered a student whom they did not particularly like as an individual. Three educators said in such cases they were more careful than usual to focus on the student's behavior and performance. Specifically, they were extra careful to review objectives that focused directly on student behavior, and to deliberately question themselves mentally prior to assessing the student performance. The fourth participant stressed it was much easier to spend more time with a student you did like. Thus, although avoiding a disliked student was not a conscious act, it likely did happen some of the time.

Anxiety. Regarding anxiety of students, participants had varying perceptions. One felt anxiety could be motivating and that a certain degree of anxiety was desirable, although she did not describe the behaviors that indicated a student had the "right" amount of anxiety. Two other participants stated most students have some anxiety and it did not concern them, unless they felt is was a contributing cause when a student's performance was substandard.

The final educator to comment on student stress and anxiety felt an instructor's behavior strongly affected a student's stress level. She stated she consciously worked on reducing this stress in her relationships with students because she knew anxiety could severely affect a student's performance.

Caring. The demonstration of caring, sensitivity and warmth toward patients were characteristics four participants stated they looked for in every student. These instructors realized their evaluation of these qualities were subjective. One participant said although there was not a clinical objective for caring in the program, she felt it was essential and would always look for it. One educator specified that she especially looked for caring in male nursing students.

Age . The participants who discussed the topic of student age had varying responses. Two stated age made no difference to them or their expectations, while the other two instructors felt it did make a difference. One participant felt that an older individual was at an advantage over a younger student since an older student would have more life experiences and be more responsible. The other participant who felt age made a difference stated that older students were usually more creative. Both of these instructors reported they had different and higher expectations of older students than for younger students.

Maturity. Three participants differentiated mature student status from the older student. Some mature students are not much older in age than the general student but most have "out-of-school" responsibilities. One participant stated her bias with mature students was to be more lenient and understanding with them than with the younger, less responsibility-laden student. Single mothers were identified as the group which this instructor felt most compassion towards and admitted to "bending over backwards" to help them through the program. A different participant agreed that a student's past experiences, and not so much their age, were the basis of her interpretation of mature student status.

Physical Characteristics. The physical characteristics discussed by the participants that influence their subjectivity in clinical assessment were height, weight, nails and dress, and posture. Three instructors who discussed height differed in their perceptions. One educator stated she might find it intimidating if a tall student had aggressive mannerisms. One participant said that almost all students are taller than she is and she did not think it affected her evaluations. One instructor, who was quite tall, stated short students sometimes appear aggressive, with the exception that short Oriental students do not seem to display this aggression. This applies to both male and female students. This respondent indicated that this observation of height did not influence the evaluative process but that the aggressive mannerisms did have an influence.

Two participants discussed the situation of an overweight student but they did not hold adverse feelings toward that characteristic. Rather, they acknowledged giving such students extra consideration. One instructor admitted she often found these students tended to be a little slower in their actions at times, probably due to the weight problem and the slowness of performance did affect the performance evaluation.

One participant commented the condition of a student's nails and dress influenced her subjectivity. The state of the student's uniform and shoes, especially if ill-fitted or unclean, colored nail polish and incorrect posture were reported to have a negative influence on her subjectivity and performance evaluation.

Overall, some physical characteristics influence instructors more than others. Some of the participants stated the student's physical appearance was of no concern to them provided the student adhered to school policies of dress and appearance. If a student violated these policies, the respondents felt the resulting effect was not subjective, but belonged in the objective domain.

Facial Expressions. The facial response a nursing student gives when questioned by an instructor affected the subjective impression one participant developed. This interviewee looked unfavorably at a student who would show disgust by "rolling up their eyes" when challenged. This was considered an immature response. On the other hand, the student who developed a "sullen or downtrodden look" also affected her assessments. This instructor would prefer a student to show some assertiveness by quickly answering the question or admitting she did not know the answer.
The second participant stated she watched for signs of interest and enthusiasm. Another participant stated she watched for students who "looked uncomfortable" either at the bedside with a patient or in conversation with the instructor. This instructor found it difficult to communicate effectively with such students.

The participants reported facial expressions are difficult to describe and evaluate. However, the influence of these expressions was sufficient to cause instructors to think them during student clinical assessment.

Voice and Speech. Voice tone and volume, as well as the speed of speech were discussed by three participants. Slow speech increased their subjectivity and caused them to observe the student for mental slowness although these educators acknowledged slow speech did not relate to mental slowness.

One of the above participants also stated she did not like students to talk loudly or with an aggressive tone of voice in clinical settings or in group discussions. This participant stated she listened for "warmth" in the tone of voice. This "warmth" was a subjective opinion and she did not describe its characteristics.

A third educator commented that when some students get anxious, they make inappropriate comments near a patient. The participant viewed these comments negatively and as a reflection of the student's poor level of personal control.

Initiative and Interest. Two participants stated they valued expression of interest and initiative in a student. The ways a nursing student could express these attributes was through "facial expression and positive attitude." The educators stated that even the weak student was viewed more favorably if he/she "showed interest." The exact way these instructors evaluated this attribute was acknowledged as being individualized and subjective.

Responsibility. The manner in which a student responds to having made an error was a characteristic two participants felt affected their subjectivity while evaluating students. One respondent felt her subjectivity was less affected if a student who had made an error admitted it and took responsibility for it rather than offer excuses about the incident. The second participant strongly disliked it when a student presented excuses for an error. Both perceived that their bias lay with the student's acceptance of responsibility, rather that with the error itself.

Analysis of Question Two

Research question two was developed to collect the perception of instructors regarding student behaviors, characteristics, and other personal factors related to the clinical environment. The eight participants presented numerous issues of varying opinions. Some of the issues discussed were not within the control of the student such as their gender, age, racial origin, and height; other issues could be under the student's control such as facial expressions, acceptance of responsibility, personality, appearance, initiative and self expression.

Some of these student characteristics and behaviors encouraged positive biases in the educators while others created negative impressions regarding the student. Some physical characteristics influence instructors more that others. All participants agreed these perceptions and feelings had a subjective influence on the clinical evaluation process. However, the participants in the study did not indicate that a student's demographic cues or physical appearance were major factors affecting their assessments. This finding is a slight contradiction to what De Meuse (1987) stated when he reported that in 81% of the studies he reviewed, "demographic variables had a significant effect on performance ratings and/or employment decisions." However, it was estimated that in the majority of instances, only between 1% to 5% of the appraisal variance was explained by the demographics cues. The influence of appearance was only researched in one study reviewed by De Meuse; it reported that appearance was most significant when the performance was poor. Ratees viewed as attractive received higher ratings than less attractive ratees when performances were poor. De Meuse concluded that more research should be done regarding the influence of non-verbal behavior and demographic cues on performance appraisal.

It should be noted that the first meeting with a student group during a clinical rotation often does not occur in the clinical setting. In conclusion, the student's clinical evaluation could be affected by the impression they portray to an instructor when they have not yet even been oriented to their designated clinical setting, and certainly have not had the opportunity to display their performance abilities to the instructor.

Research Question Three

The third research question in this study was: How do instructors deal with subjectivity in clinical evaluation of nursing students? This question was designed to explore data regarding what strategies nurse educators utilize when dealing with subjectivity in the clinical setting. Table 3 illustrates the various strategies instructors stated they had used to reduce subjectivity in clinical evaluation.

Table 3

Strategies Utilized by Instructors When Dealing with Subjectivity

Strategy	Frequency N = 8
Awareness of Subjectivity	5
Self Evaluation	3
Additional Instructor Input	2
Verbal Feedback to Students	2
Data - objective Comparison	2
Skills checklist	2
Objective terminology	2
Data Reassessment	1
Point System	1
Student comparison	1

Awareness of Subjectivity. Five of the eight participants in the study discussed their perceptions regarding the influence awareness of subjectivity had on their clinical assessments of nursing students. Three instructors felt as they became more aware of subjectivity, the influence subjectivity had on their clinical evaluations decreased.

One educator stated, "I ask myself how much is my subjectivity in play in this situation?" The process of thinking about what information regarding a student was factual and objective data as differentiated from opinions and assumptions helped one participant become more aware of her biases. One of these instructors stated, "you have to be aware of subjectivity in order to reduce its influence on your thinking, assessments and evaluations." A third respondent stated that as a result of her awareness of subjectivity she made sure to give examples of situations to verify her assessments of students and felt this process helped reduce subjectivity in the performance appraisals she developed. A fourth educator discussed how her awareness of cultural stereotypes had made her "work harder" to be more objective and less subjective when dealing with students from various cultural backgrounds. The last educator to comment on awareness of subjectivity stated she was aware of many of her biases and thus confident that she did not prejudge others. The awareness of her biases enabled her to more objectively assess students and situations.

Self Evaluation. Three participants stated they required their students to complete self evaluations during the term. The frequency of these student self evaluations ranged from weekly to occasionally depending on the instructor. Two participants stated that these self evaluations could be at the discretion of the student.

One educator stated she would read a student's self evaluation and compare it to her assessments of the student. The educator would then discuss the similarities and differences with the student. According to another instructor, the purpose of the self evaluation of the student was to verify the assessments made regarding the student. In the event that the two assessments were significantly different, then an interview would be scheduled with the student.

The last instructor to discuss student self evaluation stated she expected students, in their self evaluations, to identify what they perceived as their strengths and weaknesses. The student's comments assisted this educator to assess each student's expectations and goals. Sometimes these self evaluations were done at the commencement of the course and thus provided a basis for discussion which helped the instructor meet and get to know the student, and enabled the student to become more familiar with the instructor. This participant felt this self evaluation process reduced subjectivity in clinical evaluation of students.

Additional Instructor Input. Two participants stated they thought the inclusion of another instructor's assessment into the clinical evaluation process decreased subjectivity. However, each described different roles for the instructor input.

One participant stated that with a difficult student, or a student who was assessed as weaker than average, she would have another instructor review her notes of the student's performance to verify or challenge the evaluation. The two instructors would then discuss their assessments in an attempt to reduce the inclusion of biases and subjectivity in the process.

One participant stated at her institution there was a course level coordinator available to discuss any student concerns that an instructor might have. This person was consulted on several occasions regarding student situations or problems. It was felt the utilization of this coordinator, who was not involved with the clinical setting, was an effective way to reduce subjectivity in clinical evaluation.

Verbal Feedback to Students. Talking to students who did perform at average or below average level and discovering how they perceived situations was a strategy one participant felt helped reduce subjectivity in clinical evaluation. By being aware of the student's perceptions of her/his performance, this educator felt she could reduce the amount of subjectivity in the evaluation process.

A second participant specified talking to every student to verify their understanding and perceptions of situations and performances was essential if the evaluation process was to become less subjective. This educator felt every inference made regarding a student's performance, ability and attitude by an instructor had to be discussed with the student to establish the credibility and accuracy of the inference.

Data - Objectives Comparison. Two participants felt it was beneficial for them to write out their data and compare it closely to the course objectives. One of these educators stated since she was new to teaching nursing students (less that one year of teaching experience), she found it essential to compare what she had observed and what her thoughts were, to the written course objectives. This process, she thought, helped reduce her subjectivity in evaluation and keep her student assessments more consistent with the course objectives and expected performance levels.

Skills Checklist. Criterion referenced skill checklists were viewed by one instructor as being helpful in assessing performance skills in a more objective way. The objectivity increased because every student was observed and compared to a predetermined criteria and a specified sequence of expectations. This participant felt the decisions of the observing instructor could then be considered objective, and that subjectivity did not enter into this type of evaluation.

The second participant to discuss this topic stated it would be nice to have a criterion referenced skill for every behavior required of nursing students, but felt that this was more theoretical than practical due to the numerous variables which could occur. However, in the lab situation, and with some skills, this instructor felt the skills checklist was valuable in reducing subjectivity and increasing consistency between instructors.

Objective Terminology. The use of terminology which is objective and descriptive in nature when evaluating a nursing student (such as completes morning care consistently or adheres to aseptic principles appropriately) was felt to decrease subjectivity in clinical evaluation for two participants. Terminology laden with subjective inferences (such as wonderful attitude, nice work and pleasant student) were felt to increase subjectivity. The words used in the evaluation should be carefully chosen so that the student, and any subsequent readers, would derive the intended message from the evaluative comments. The two participants who presented these opinions stated they felt only factual, measurable, and observed behaviors or events should be included in a clinical evaluation. Opinions or inferences should not be included in the evaluation unless substantiating documentation was available that was free of bias and subjectivity.

Data Reassessment. The participant who presented this strategy as a means of dealing with subjectivity in clinical evaluation stated she reassessed data collected regarding a student when she rewrote her notes and then reread them. This was especially helpful when dealing with personality clashes as this process assisted her to separate facts from conjectures she might have made.

Point System. One participant had developed a system whereby a student was assessed against numerous markers throughout the clinical posting. A student would be awarded a numerical point against a scale for various performances (some written and some behavioral performance). When evaluating the student, the subjectively assigned numbers were tabulated, and the student's overall grade was based on this system. By assigning many numerical grades to each student, if the student had an atypical day for his or her ability, then it would not severely affect the overall grade. This instructor frequently verified the findings with the student in an interview to keep the process "fair" for the student. The educator had used this "self designed" system for many years and found it was quite accurate in determining a student's ability.

Student Comparisons. One participant noted there is a tendency to compare one student's performance to that of another student. This instructor felt since she had started making a conscious effort to avoid comparing students with each other, she had reduced an area of subjectivity in clinical evaluation. She felt each student should only be compared to the course objectives, and not to another student.

Analysis of Question Three

All of the participants in this study discussed at least one strategy they had employed in dealing with subjectivity in clinical evaluation. They indicated they had not thought a great deal about the strategies they had used before the interviews for this study. Based on the discussions, it is apparent that the educators had developed strategies for handling various situations and had utilized them during clinical evaluation, but had not regarded them as a technique or strategy before this study.

All of the instructors expressed concern about subjectivity in clinical evaluation of students and all strived to work with subjectivity in their own ways. Although the respondents did not discuss if they thought they were the only instructor concerned regarding subjectivity it seemed as if they were unaware that their peers also struggled with subjectivity and how to deal with it. The participants indicated there was not very much direction or assistance available to aid instructors who were struggling with a difficult situation unless it dealt with an issue governed by school policies. If an educator was troubled by subjectivity it was deemed to be her problem and she should solve it; to admit a bias was generally considered unacceptable and frowned upon but no real assistance was offered.

They all indicated they intended to be as fair as possible with every student and some indicated that at times they felt inadequate to deal with some student situations. Karns and Schwab (1982) and Wood (1985) found that although instructors were considered to be prepared for their teaching positions, they were inadequately educated in clinical teaching and evaluating skills. The findings of this study seem to support the conclusions found in the literature.

In conclusion, it was found that instructors were concerned about subjectivity in the clinical evaluation of nursing students. They seemed to find that the concept of subjectivity was very complex and not easily controlled.

CHAPTER V

RESULTS AND ANALYSIS OF THE SECOND INTERVIEWS

This study explored subjectivity in clinical evaluation of nursing students as perceived by nursing instructors. The study was designed so each participant was interviewed at the beginning of the spring 1989 term with a new group of students, and then again approximately 5 to 8 weeks later, after at least one written evaluation of each student had been completed. The findings of the second research interviews are discussed in this chapter by the three research questions.

During each interview, the participants discussed situations, and student characteristics and behaviors they perceived influenced their subjectivity in clinical evaluation of nursing students. The instructors also discussed strategies they used when working with subjectivity during clinical evaluation. Although only two or three educators commented on some topics, their responses did comprise twenty-five to thirty-seven percent of the total participant group. Remembering that the study was exploratory in nature, and the total study group numbered only eight, the perceptions of even a few were felt to be noteworthy by the researcher and are thus presented and analyzed.

Research Question One

The first research question related to the influence of subjectivity in the clinical evaluation of nursing students. Some of the topics presented for discussed by the participants in the second interview are different than topics discussed in the first interview, while other topics are repeated. The topics were initiated by the study participants.

In some cases, respondents commented on topics during the second interview that had been raised in the first interview. Table 5 shows the distribution of instructors who discussed the same topic in both interview one and two. Usually the respondent's comments were different in the second interview than in the first interview or, at least, were expanded versions of their original comments. Only once in the study did an instructor repeat her comments exactly in both interviews without adding additional comments. On no occasion did a participant contradict his/her statements from the first interview during the second interview.

Table 4 identifies the participants in the study by the initial of their assigned pseudonym and lists the number of respondents who commented on each topic repeated in the two interviews. Only the initials of the instructors who repeated their comments are listed for the second interviews. Table 4 also indicates the total number of topics discussed during each research question in each interview, not just the number of topics repeated. Only a minority of topics were repeated in the second interviews. Fifty topics were discussed in the study; with only ten topics repeated by the participants in the second interviews. Where discussion of a topic by the same educator occurred in both interviews, the discussion of the repeated information will be brief in this chapter.

Table 4

Repeated Topics in Interviews 1 and Interview 2

	Interview 1 **N = 8**	**Interview 2** **N = 8**
Repeated Topics	**Initial / responses**	**Initial/ responses**
Question 1	**Total Topics =10**	**Total Topics =10**
Presence of Subjectivity	A B C D E F G H / 8	A B**C D E F G H / 8
Input from others	A C D E F / 5	A C D E / 6
Previous Evaluations	B D E F G / 5	B* G / 3
Instructor Experience	A C E F H / 5	A** / 2
Patient Assignment	A B / 2	B** / 5
Question 2	**Total Topics =15**	**Total Topics = 5**
Responsibility	G H / 2	G / 2
Question 3	**Total Topics =10**	**Total Topics =10**
Awareness of Subjectivity	A D E F H / 5	A D** E F** H** / 8
Self Evaluation	E G H / 3	E / 2
Additional Instructor Input	E F / 2	F / 4
Verbal Feedback to Student	E H / 2	E** H / 8
	Total Topics =35	**Total Topics =25**
		Repeated Topics =10
		New Topics =15

Note. * = exact same comments
** = same comments plus additional comments

However, only on one topic (Question one - previous evaluations) did a participant repeat her comments from the first interview without elaborating on her views. All other topics with repetitive remarks by an instructor included additional perceptions.

The discussion in interview one for question two was detailed and lengthy which might explain why participants only discussed five topics during interview two. During the second interviews the participants showed the greatest enthusiasm and interest in discussing the third research question which dealt with strategies they used to deal with subjectivity. This may have happened because the respondents thought more about strategies following the first interviews. Six strategies which had not been mentioned in the first interviews were initiated and discussed during the second interviews. Also noteworthy, is that for each topic repeated, participants who had not previously commented chose to discuss this topic. It would seem that the participants in the study while working with their clinical group of students, had made a mental note to remember and report to the researcher about what they actually did when dealing with subjectivity during the clinical evaluation process. The educators did not identify these as new strategies they had just developed since the start of the study, but rather the impression received by the researcher was that these strategies were not new, just that they had not been discussed in the first interview. For example, verbal feedback was discussed by six respondents in the second interviews who had not discussed the topic in the first interview. All of these educators indicated that they had always used verbal feedback to students to validate their assessments, but indicated they had not previously thought of it as a "real" strategy in reducing subjectivity in clinical evaluation.

The two topics which were discussed most were "subjectivity in clinical evaluation" in question one and "awareness of subjectivity" in question three. In total, 29 of a possible 32 instructor comments were made on these two topics. These discussions further indicate that in addition to their volunteering for the study, the participants were genuinely interested in the topic of subjectivity and its impact on clinical evaluation of nursing students. Individual instructors further discussed particular perceptions and ideas as related to the three research questions. Of these more specific topics, verbal feedback was discussed by all eight instructors, and input from others was discussed by seven different educators. Several topics were discussed only in one interview during the study, but by several instructors during the one interview (as shown in Tables 1 to 7 in Chapters IV and V). There does not seem to be a logical reason why a topic discussed by seven instructors in one interview was not discussed at all in the other interview. For example self expression as a behavior of students and written feedback to students as a strategy were discussed by seven instructors each in interview two but neither were mentioned in the first interview. Table 5 lists the topics related to question one as reported by the participants in the second interviews. The topics are listed in descending frequency of response.

Table 5

Factors Influencing Subjectivity in Clinical Evaluation

Topic	Frequency N = 8
Presence of Subjectivity	8
Time with Student	6
Input from Others	6
Patient Assignment	5
Assignment of Grades	4
Fair Judgements	3
Previous Evaluations	3
Student Experiences	2
Instructor Experience	2
Previous Instructors	1

Presence of Subjectivity. As can be seen in Table 5, all of the respondents during the second interviews commented they felt certain that subjectivity was present in the clinical evaluation process. One participant stated that evaluation would never be free of subjectivity as long as those doing them were human beings. A second educator said much the same thing when she reported "you have feelings about every student, you have to or you'd be like a robot." These two instructors believed that as soon as "feelings" enter the evaluation process, subjectivity is present.

One interviewee reported she felt her subjectivity entered the evaluation process when she allowed her personal preferences, rather than just the objectives, to guide her in evaluating a student. Several participants reported they acknowledged they had biases toward certain behaviors they could not ignore, such as giggling and gum chewing. Some of the nursing schools where some of the respondents in the study were employed did not have policies and objectives to address the described actions, but these instructors stated they had definite feelings about the behaviors. Thus feelings these actions invoked in the instructor did influence the clinical evaluation process.

One participant offered an example that included a specific course objective. All nursing schools have objectives regarding safety, and when a nursing student makes a medication error, the instructor felt that subjectivity still entered the process by what she did about the incident, how the event was investigated and how the student was treated following the mistake. The judgements made by these educators, even when dealing with specific objectives, were reported to be where subjectivity entered into the clinical evaluation process.

One participant described herself as a "tolerant" person who always tried to see things from the student's point of view. She stated this activity helped to reduce the affect her biases had on the evaluation process.

Time with Students. The major theme that developed from the analysis of the comments regarding the time spent with students was that more time was spent with a student who had been identified as weak. Sometimes a weak student was not identified until late in the rotation and thus was not assisted as much as the instructors felt was desired. The concern of several of the respondents was that if an instructor had a weak student who required a great deal of time, then the remainder of the student group received less instruction. This was thought of as unfair to better students who deserve as much time with an instructor as do weaker students.

None of the instructors kept a record of time spent with any student, but all acknowledged it was probably not evenly distributed. Two participants stated that at times they felt guilty about not spending an equal amount of time with each student. One instructor reported a negative aspect of spending more time with a student, especially a weak student, was that it enabled the educator to see more mistakes made by that student.

Another educator stated the length of the postings was quite short and that often an instructor would have to evaluate a student's performance after only 12 to 18 clinical days of experience. She was concerned that the short duration of rotations did not allow students enough time for learning and practice before being evaluated. As a result she felt this put pressure on an instructor to evaluate every student behavior observed, starting the first day on a new clinical unit.

Input from Others. Input from others was a common topic discussed by the instructors for question one during both interviews in the study regarding question one. During the second interviews, six of the eight instructors reported they use information they acquire from other people in the clinical evaluation of nursing students. One of the participants stated her clinical group of students work with patients during weekends, so this second "weekend" instructor routinely contributes to the evaluation.

Four participants said they do ask staff for their comments regarding general information about a student's performance, but that sometimes they did not seriously consider all of the reports, especially those from staff members with a reputation of being difficult to students. One respondent commented if data from the staff did not verify assessments of a nursing student she had developed, she often dismissed it - especially if it was negative feedback.

Staff comments were reported to be of most value when the staff member had observed a student doing a skill, or in the realm of communication. "The manner in which a student functioned as a team member" and "reported data to the staff" were two areas most often utilized in developing the student's evaluation.

A third category of people from which four educators sought information regarding the student was from the patients. However, three instructors stated they reviewed these comments carefully because some patients are quite critical of a students in general. The most valued comments from patients were in the domain of a student's communication skills.

Patient Assignment. Five participants reported they felt patient assignments influenced clinical evaluation. Four of these five participants said they had motives and purposes for the assignments selected for students. One educator stated she tried to select equally challenging assignments for each student, but the availability of patients dictated what experiences were available. Stronger students generally received more challenging patients. One instructor reported she sometimes would give an average or weaker student a difficult assignment, then work with the student to discover what her needs for instruction and assistance were.

Another instructor stated one of her motives when she selected patients assignments for a student was to collect data on a student. If she had not observed a student doing a particular skill, or the student had previously done the skill poorly, then the instructor would select that experience for the student with the intention of observing the student's performance. However, all the respondents agreed patient safety was considered before selecting patients for any student assignments.

Only one educator let students choose their patient assignments. If a nursing student always chose "easy patients" for his or her assignment, even if those patients were well cared for, the student would receive a low grade. The students who selected "challenging patients" for their assignments would likely receive higher grades. This instructors' students were aware that their patient selection would be reflected in their grade.

Assignment of Grades. Four educators reported they felt subjectivity did influence the grades students were assigned. Clinical grades are not based on written tests but rather on student performance in the clinical environment. One participant stated that at her nursing school, numerical grades from one to four were used, with one being low and four being the highest grade. She felt when she assigned a grade of three to a student she was consistent in her expectations of what a three meant for all of her students. However, this educator felt there was the possibility that another instructor, in the same school, could assign a different grade for the same quality of performance.

The three remaining participants who commented on the issue of assigning clinical grades all stated how difficult it was to give a poor grade to a student. One educator reported "there is so much work involved in failing a student," but that she could never pass an undeserving student. The amount of feedback for a poor student was considered to be much greater by these interviewees than for average to excellent students.

Fair Judgements. Of the three respondents who discussed the topic of judgements made by instructors, two were concerned about leniency. Two examples were cited where circumstances led to lenient judgements by educators of nursing students. The first example was a situation were the educator acknowledged a dislike for the student as a person. Thus, the instructor in an attempt to overlook the feeling of dislike, judged the student too leniently. Later in this student's program, another instructor who also admitted not liking the student, critically evaluated data indicating that the student was not at the expected level. The educator who overlooked the earlier inadequate performance of the student, in fear of being influenced by her dislike of the student, had done the student an injustice according to the second respondent by allowing the student to believe that she was performing adequately. The second participant felt that observed data collected of poor performance should not be ignored. regardless of subjective influence.

Subjectivity enters into most judgements made by educators according to a respondent. As a rule, she would never include on an evaluation "a one time event or error," unless it was "really serious or showed very poor judgement" on the part of the student. Subjectivity occurred when the instructor decided what was serious or what showed poor judgement. The participant felt she was consistent in her judgements, but acknowledged that other instructors might have different views and actions in the same situation.

Previous Evaluations. The influence perceived to result from reading a student's previous evaluation was discussed during the second interviews by three respondents. One instructor, who did not discuss this topic in the first interview, reported she would not usually read student's previous evaluations because she felt they "would sway" her opinion. She would read the evaluations after working with a student if the student was doing poorly, in her assessment, midway through the rotation in order to verify if the problems had previously existed. She reported, that this information helped her in planning a strategy to assist the student.

The other two instructors who discussed the subject of reading past evaluations had opposing viewpoints. One stated she read a student's past evaluations and would talk to the previous instructors if deficiencies had been identified. She felt this enabled her to start working with the student immediately and reduced the time used in assessing the student.

The other educator felt reading previous evaluations might influence her assessment of the student. She stated that previous instructors could have missed problems the student had, and if she was biased by their assessment, she might not identify other problems because of focusing on specific behaviors noted in previous assessments.

Student Experiences. The two respondents who elected to discuss the influence that a student's past experience had upon their expectations of the student presented different views. One participant cited the example where a student in the nursing program had previous experience in a related health care role such as a registered nursing assistant. This instructor felt that she had higher expectations of that student, and her experiences with such students verified that these students did perform at a higher level that those with no or limited experiences.

The second participant stated her expectations of students increased as the academic year progressed. Clinical rotation schedules are usually assigned by Schools of Nursing and not selected by students. Students will rotate to various clinical units throughout the year. That is, a student may go to the pediatric unit in September while another student may not go to that unit until May. In the meantime, students are gaining clinical knowledge and skills on the various units in which they are working. Thus, they have achieved a higher level of nursing performance generally due to experiences, practices and maturity throughout the academic year.

Instructor Experience. As shown in Table 5, two participants discussed their ideas regarding the influence that the instructor's past experiences have on clinical evaluation of nursing students, specifically job-related experiences they'd had. Previous experiences with a nursing union had led one instructor to carefully analyze what she observed of a student and what she perceived of the event. She "might let something go" if she felt the data were even slightly inconclusive or difficult to substantiate. This instructor stated that she wrote clinical evaluations of nursing student utilizing descriptive and objective terminology.

Conversely, the second respondent reported that if there had been problems in one rotation this instructor would start "the next posting by letting the students know my expectations right away in a way I don't usually do." This was done to clarify any misconceptions, doubts, or fears that the students may have developed from comments made by a disgruntled student from the previous rotation. The influence of one group of student over a subsequent group of students had not previously been mentioned by any of the instructors in this study.

Previous Instructors. Although only one participant commented about the influence of previous instructors on student performance, it was decided by the researcher to include this finding due to small number of total participants in the study. The idea presented by this respondent was unique and thought provoking. This instructor would look at a student's records, or ask the student, from which faculty members he/she had received instruction. The respondent felt that if the previous instructors were faculty members who shared her values and expectations, then she would feel the student had been instructed and evaluated from a standard she respected. If the student had been taught by instructors she did not respect or trust, then she would more cautiously assess the performance. It should be noted that nursing students usually have no control over the choice of instructors.

Analysis of Question One

Question one focused on the general topic of factors which instructors perceived to influence subjectivity. The comments from the respondents indicate that a student's evaluation could be subjectively influenced by factors over which the a student has little or no control. Some of these include the time of the year a student goes through a clinical posting, the past experiences of an instructor, the compensations that an individual educator might chose to make depending on a situation plus previous educators of a student. The degree of subjectivity in the clinical evaluation process appears to vary, but it is acknowledged to exist by all the participants of the study.

The most common theme of the discussions in the second interviews, as in the first interviews, was that subjectivity enters into the process of evaluation wherever interpretation begins. In contrast, the participants described objectivity as that which is limited to observable behavior plus what's heard, read or seen. It seems impossible to avoid subjectivity even when evaluators are trying to be as objective as possible. These thoughts are in keeping with the findings by House (1977) who stated that objectivity is when the observation is factual but when it includes a bias, you have subjectivity. House further states that the rater must be interested in evaluation accuracy and attempt to be free of biases.

The respondents in this study reported the following reasons for subjectivity: being human, having personal values and biases, having preferences and being individuals. This supports Infante's (1985) statement that interpretations of data can vary from educator to educator but can also vary from time to time, or from student to student for the same educator.

The humanism and uniqueness of student- instructor interaction seemed to have a strong influence of the educators in this study. They reported numerous situations and issues which they identified as areas affecting subjectivity. At times, they spoke of these situations with a softness and pride, but at other times some of them appeared to be frustrated with the abstractness and vagueness they felt when having to evaluate and judge the students with whom they had interacted.

Guilt seemed to be a common feeling participants described regarding the variance of time spent with each student. That weaker than average students required more teaching and supervision time than stronger students was acknowledged by most of the educators. This unequal division of time spent with students was felt to increase subjectivity in clinical evaluation. Instructors observed the weak student more thus observed more performances and mistakes of the weak student. Due to reduced time available to observe the presumed stronger student, less errors and/or outstanding performances were observed and assessed. It would seem that the amount of time instructors spend with each student is decided by the educator in a subjective manner and the time spent observing a student directly influences a student's assessment.

The instructors reported that information received from staff members, patients or other instructors comprised only a portion of the total evaluation of a student. The comments of the respondents indicated that they acknowledged that there could be some subjectivity within the comments from these other sources, and that they analyzed the data before absorbing the information into the student's evaluation.

However, the educators acknowledged that even when they did not consider or act on the comments, the fact they had heard the comments made them think more about the student, thus subjectivity was increased. This awareness seems to support Sherman (1979) conclusions about referral information. Sherman stated that all information received will influence the evaluator, regardless if the information is referred formally or by hearsay. The participants in the study did not indicate a formal awareness of the residual effect of any, or all, referral comments but the fact they all discussed input from others might suggest they were cognizant of it.

The margin for inconsistent grading between educators teaching the same course was a concern for some instructors in this study who felt that grade assignment was probably inconsistent. It seemed as though within the peer group of instructors teaching a course there was a lack of trust that each would evaluate students with equal leniency or strictness. This suspicion of inconsistency seems warranted based on what Woolley (1977) reported from the Haytor study in which instructors who viewed a film of a student performance had only 44 percent agreement in the grade they assigned to the performance. These educators rated the same performance from well below average to excellent. Numerous explanations by the evaluators indicated that many variables outside of the actual performance were included in the rationale for the grade assigned, even though those variables were not within the student's control or actually affected the performance.

In this study, how the instructors approached and dealt with a weaker student varied and each made his/her own decisions with the policies of their nursing school. These decisions were considered to be subjective by the instructors because they each had their own way of approaching such a situation and their own strategies to assist the student. The possibility that another educator might not fail the same student, given the same data and events, was discussed. It was noted that each educator had to strive at being consistent with course objectives and expectations, but that in reality subjective decisions sometimes have to be made in the process of evaluation. These findings are in keeping with what Schneier, Beatty and Baird (1986) who state that evaluators use their own experiences, biases and style when making ratings but that the success of performance appraisal can be increased by having objectives, behavioral criteria and a competency based system for a base.

Educators, in trying to avoid harsh judgements of their students may have been influenced by what Sherman (1979) discussed as the halo effect. This has the effect of creating a consistently good picture of people because negative impressions are avoided.

What is written in student's previous evaluation, in the opinions of these educators influences subjectivity. The decision to read and utilize a previous instructor's judgements and evaluations of a student seems to be subjective in itself. These educators in this study are not guided by nursing school policies regarding the use of past evaluations, and so instructors decide individually whether to read or not to read previous evaluations. The instructor may also choose to read evaluations of some students, and not to read evaluations of other students. This would also seem to involve subjective judgements on the part of the educator. The respondents in this study stated that it was also their choice to talk to other instructors about any student.

Subjectivity seems to be imbedded in the clinical evaluation process. Instructors seem to be aware of some areas where subjectivity has an influence, but they did not indicate confidence that they could always satisfactorily control subjectivity, or its influence, on their assessment of nursing students.

Research Question Two

The second research question asked was: What characteristics and behaviors of nursing students do instructors perceive as influencing factors on their subjectivity in the clinical evaluation process. Table 6 illustrates the topics which emerged from discussion during the second interviews.

Table 6

Student Characteristics and Behaviors Influencing Subjectivity

Characteristics and Behaviors	**Frequency N = 8**
Student interaction	3
Responsibility	2
Patient teaching	2
Speed of Performance	2
Physical Appearance	2

Student Interaction. Three participants in the study, when discussing the topic of student interaction with an instructor, stated there were a few characteristics that concerned them in a subjective manner. For example, if a student acted in a very "hyper" manner when the instructor was present (as indicated by a change in voice tone, and/or mannerisms became abrupt and almost erratic), this influenced the assessment. The student might still perform adequately but the change in behavior affected the instructor's opinion of the student's ability to cope with stress.

One respondent stated she had a preference for students who "open up to discuss," and that she found it difficult to work with students who only answer questions when asked and never elaborate on their ideas and concerns. This instructor had previously worked with students in a graduate nurse preceptor role, and felt that those students were much more open during discussions with her because she had a less authoritarian position. A lack of interaction caused the educator to question whether students lacked trust in her, thus restricting their comments, or if they were always like that, even with patients.

The third participant expressed a concern with students who say they are "so nervous" when an instructor is nearby. She felt it was difficult to assess these students because when they were observed doing a skill, they would tremble, use inappropriate phrases, and perform poorly. However, staff comments, often indicated that these students did quite well whenever the observer was not an instructor. When questioning such students, they would acknowledge that the educator's presence did cause them to make mistakes, even when they knew the correct skill, but that they could not seem to control themselves. The participant reported that almost all students experienced some anxiety when their instructor was present but they still managed to perform correctly. The heightened stress and altered performance in some students caused doubts in the educator's opinion as to the true abilities of the student.

Responsibility. Two respondents reported that they assessed differently those students who arrived on the nursing unit unprepared for clinical experiences but admitted their error and showed concern regarding their lack of effort, than other students who did not take the lack of preparation seriously. The means by which the instructors evaluated "remorse and concern" were subjective, and based on their personal interpretation of the student's behavior and spoken words. The absence of concern or remorse by the student made the same degree of inadequate preparation a greater error in the opinion of these instructors.

Patient Teaching. Two respondents reported there were two behaviors students might do while teaching patients that "irritated" them. One was when a student began utilizing sophisticated medical terminology in explanations to a patient after the instructor had arrived. The educator perceived this as an attempt by the student to "impress" her with fluency or terminology. This participant did not look favorably on a student who took advantage of a situation to "show off" at the expense of good patient care.

The second respondent stated "poor grammar bugs me." But if the patient was responding and the student was providing appropriate teaching, then the educator would not discuss the incident with the student. It did, however, leave an impression on the instructor.

Speed of Performance. The emphasis on speed by a student was viewed as an overrated value in nursing education by one participant. This educator, who considered herself to be a "fast person," said that although she liked to see a student perform well, she would rather see them be careful and accurate than go quickly and make errors. The acceptance of slower performing students had been a change of assessment criteria for this instructor who's first impulse was to favor the "speedy" student.

A second respondent reported she had to make an effort not to let the slowness of a student affect her opinion and evaluation. The slowness was more tolerable if it was the first time a student did a procedure. The educator acknowledged the speed of completion was important to her but that the safe completion of a skill dominated her assessment.

These instructors stated that logically they could accept that a student would be slow with new procedures, but instinctively they preferred to see the student demonstrate some speediness, even with new skills.

Physical Appearance. One of the two participants who discussed their perceptions of students regarding physical appearance focused on tidiness of the student, especially hair style. This respondent felt a negative bias toward a student who appeared for clinical experience with an "uncontrolled hairdo." This instructor stated she felt this type of appearance "tells me something." The messy hair style biased her towards an expectation that the student would perform incompletely. Although this "incompleteness" was not always verified, the educator was still aware of the influence of this bias.

A second educator stated she had the expectation that a neat appearing nursing student would develop into a "good nurse."

She felt, in her experiences, that the bias was sometimes confirmed, but not always. When a "neat" student did not perform well, it was disappointing and contrary to her expectations.

Analysis of Question Two

In this discussion of reported perceptions by participants during interview two, are included comments which strongly support the common themes identified as well as views which were not in keeping with the opinions of others.

The opinions and perceptions expressed by these respondents indicated there are quite a few issues, including non-verbal issues which affect subjectivity in the clinical evaluation of nursing students. De Meuse (1987) determined that effects of non-verbal cues, including appearance, expressions, race, sex and attractiveness, on personal perceptions and performance appraisal vary. The respondents in this study, in the two interviews, identified eighteen characteristics and behaviors they felt affected their subjectivity in clinical evaluation of nursing students. The participants frequently did not state why or where their ideas had developed, but they were aware of them. As discussed in the literature review, writers such as Rice (1985) note the attribution theory and its significance in performance appraisal. This theory deals with how people develop inferences and "attribute" cause for actions or performance as a source for error in performance appraisal. It would seem that the educators in this study may be exercising the attribution theory when associating hair style, voice tone, gender, physical appearance, responsibility, and initiative of a student, to faults in a student's character that are undesirable for a nursing student. Considering "good" nurses come with such varied physical and personal traits, it seems that educators must be very open minded about their expectations regarding physical attributes and their implications for student performance.

Research Question Three

The third research question explored in the study was: How do instructors deal with subjectivity in clinical evaluation of nursing students? The educators were asked to relate what they did when encountering possible subjectivity in clinical evaluation. They reported many actions and strategies used when attempting to work with subjectivity; these are listed in Table 7.

Awareness of Subjectivity. All eight respondents stated they spend time identifying their biases and their perceptions of issues which cause them to be influenced by subjectivity. Three educators stated they had decreased their subjectivity by having identified their biases toward some behaviors and characteristics but that they had not become more tolerant of those behaviors or characteristics. Two other participants reported that once they were able to identify areas of bias, they became more tolerant of those behaviors or characteristics when observed in a student.

Table 7

Strategies Utilized by Instructors when Dealing with Subjectivity

Strategy	Frequency N = 8
Awareness of Subjectivity	8
Verbal Feedback to Students	8
Written Feedback to Students	6
Additional Instructor Input	4
Collect Additional Data	4
Assignment Selection	3
Self Evaluation	2
Student-Instructor Evaluations	2
Think more about Student	2
Avoid Acknowledging Subjectivity	1

All the instructors interviewed felt their level of subjectivity decreased as their level of awareness of subjectivity increased. One educator reported being aware of her biases had made a difference on how she evaluated nursing students. They discuss that raters must make a conscious effort to reduce bias as a means to a more acceptable level of inevitable bias in performance appraisal. Several participants stated they were "always thinking about subjectivity" and how to reduce its effects on their assessments. One instructor said she hoped that by questioning herself and looking for reasons behind decisions, she would become more objective. Another instructor reported that "being aware of how you respond is important," not reacting just to students and their behaviors.

A participant stated "being cognizant of subjectivity helps because there will always be personalities and that's part of being human, but being aware helps not let the biases cloud your judgements in evaluation." One of the educators in the study suggested "the biggest change in subjectivity was becoming more aware of it."

Some of the instructors in the study stated they had always been aware of subjectivity. Those who recently had given the concept more thought than usual, reported they felt the increased awareness of subjectivity had influenced their recent clinical evaluation of students.

Verbal Feedback to Students. Verbal feedback was reported by every participant in the study as a common strategy used in attempting to reduce the influence of subjectivity in student performance appraisal. These instructors stated they did not wait for a formal evaluation session to discuss student performance, especially if errors were being made. One educator stated she talked more with students as her experience increased compared to when she started teaching. She frequently had students repeat what she had said to ensure they had received the desired message.

Clarification of course objectives and expectations were strategies used to reduce subjectivity by one respondent when giving feedback to a student who was not performing as expected.

Verbal feedback to a student was reported by several of the educators to be given immediately after a procedure was completed, either successfully or unsuccessfully. One stated she felt most students knew when they performed poorly even before the behavior or performance was discussed with them. Another instructor stated that she felt a valuable component of verbal feedback was that it provided an opportunity for the students to voice opinions, explanations, and rationale for their actions.

One respondent stated it was difficult for her to give a student negative feedback, so whenever possible she would balance the negative comments with a few positive remarks in order to preserve a student's pride or self-esteem. But equally important was the message that their behavior or performance required improvement so if the negative message was too subtle, or cluttered with positive feedback, the student could erroneously dwell on the "good" comments and not receive the intended message.

One participant reported she would stop giving "only verbal feedback" to a student, and start giving "mostly written feedback" when she suspected a student was performing below average. Two other educators stated if they suspected a student was performing at a poor level, they would inform the student of their intentions to observe them more carefully. These instructors felt by giving students verbal notice of increasing supervision the students would recognize the instructor's concern regarding their performance and abilities. The instructors indicated the most common reasons for giving students verbal feedback were to increase student confidence in their performance and to verify if, as evaluators, their observations and impressions of the student were accurate.

Written Feedback to Students. Although all final evaluations must be written in nursing programs, only six of the eight participants in this study reported that they used written feedback as a strategy for dealing with subjectivity in clinical evaluation of nursing students. Four of these instructors reported students were given the opportunity to read written comments or anecdotal notes regarding themselves. One educator felt it was very important for a weak student to receive both verbal and written feedback to ensure they received the intended message.

Another participant stated her notes about students were a combination of observations and impressions. If she developed a concern about a student, she would prepare written notes for the student to read, (using objective terminology) and would include only what she could verify. Preliminary notes were made about all students, but the written feedback by this instructor was only prepared for weak students. A third educator to discuss the use of written feedback with a weak student stated that to reduce the risk of a student not "hearing" the negative comments, it was essential for the student to read negative written assessments.

Another instructor stated she always verified her written documentation by citing an example where the student had demonstrated the described behavior. This was perceived to be useful in assisting the student to recall the incidents related to the evaluative comments.

Another participant stated that written notes were an essential tool she used when dealing with several students in a clinical group. Often these notes were not shown to students, but the written comments enabled her to keep her observations and assessments of every student as documentation in the event that a pattern of weak performance was later identified. It helped her to avoid overreacting to a specific event or episode and rather to look for patterns in the student's behavior. This strategy was perceived to help reduce her subjectivity by keeping the facts documented and thus keeping her memory of the events more accurate.

Additional Instructor Input. Four participants interviewed stated they talked to other instructors when they have a concern regarding a student to ensure their expectations are within the course objectives and expectations. They reported they tried to describe their observations as objectively as possible to their colleague. Two respondents acknowledged they could influence their colleague by the manner in which they presented the data, or by expressing their feelings, but if their bias during these discussions were revealed, it was unintentional.

One participant acknowledged she talked to other instructors when she had a concern, because she needed reassurance that there was a legitimate concern. This was an attempt to reduce the influence a personal bias or preference might have on the situation. If the other educators thought that she was "worrying for nothing or over-rating the event" then she would reconsider her judgements.

The nursing school in which some of the participants taught was able to provide an additional educator to come to the nursing unit if a clinical instructor felt a second evaluator might be of assistance with a specific student in helping to reduce subjectivity in the evaluation process.

Collect Additional Data. Four participants stated when a problem was perceived, they would seek further data to verify if a problem truly existed or if they had erred in their perception. This search for additional data also occurred for one instructor when she perceived a student might be exceptional.

One educator reported she would tell a student he or she was going to observed more often and more closely than in the past, because of a concern about their performance. The instructor felt this approach was fair to the student.

Assignment Selection. Purposeful selection of patient assignments was a technique three participants stated they used to provide students with every possible opportunity to meet objectives and their needs. One participant stated if she had perceived a student had difficulty with a particular experience or skill, she would select that experience again for the student to either confirm her perception or to allow the student to master the skill. The student's learning needs were a priority for one educator when selecting patient assignments for students. This respondent felt a student could only achieve the objectives of a course if given the opportunity to practise and demonstrate the necessary skills and abilities. This instructor felt it was her responsibility to assist each student meet the objectives by selecting appropriate patient assignments.

Self - Evaluation. Two educators in the study felt that having students do weekly or biweekly self evaluations helped them improve. One instructor noted that students do well when they identify their own areas of need. In both cases, students' self evaluations assisted the educators to work more closely with the students.

Student - Instructor Evaluation. The two respondents to comment on their use of instructor evaluations written by students both stated they took the information seriously. One participant reported that if the students identified an undesirable pattern in her performance she attempted to correct it. The other instructor stated she set goals for her improvement from information gained from the instructor evaluation forms.

Think more about Students. Two participants reported they spent significantly more time thinking about students they perceived had problems, or students they had difficulties with compared to students with whom they did not have concerns. One instructor in the study stated she used the approach of thinking more about her biases and values and the possible influence they had on the situation. The other respondent reported spending more time thinking about a student and reviewing collected data before proceeding to "check them out one more time."

Avoid Acknowledging Subjectivity. One participant felt that she disagreed with other instructors whom she had heard say subjectivity did not exist in clinical evaluation, provided there were course objectives . This respondent felt this was an attempt by educators to deny subjectivity. She believed that acknowledging the existence of subjectivity and then working with that acceptance was an important step for her in attempting to reduce subjectivity in clinical evaluation.

Analysis of Question Three

The participants in this study all had strategies and techniques they felt helped them to work with and reduce subjectivity in the process of clinical evaluation. The two strategies all participants utilized were awareness of subjectivity and verbal feedback to students. All respondents reported they felt there was a reduction in the influence of subjectivity as awareness of their biases and their concept of subjectivity increased, but that subjectivity still affected their clinical evaluations. All instructors stated they frequently talked to their students and gave feedback to them regarding their progress. Written feedback was reported to be utilized more often with weaker students than with the average or strong student. All final evaluations were written.

The participants, while discussing the third question in this study, reported their perceptions and feelings, as well their strategies, regarding how they worked with subjectivity and attempted to reduce the influence of subjectivity in the process of clinical evaluation and increase the accuracy of their assessments. It appeared that the instructors in the study were reporting what they had learned from their teaching experiences, rather than whatever they may have learned during their formal educational preparation for their role of nursing educator. Karns and Schwab (1982) reported that teacher preparation focused almost entirely on classroom skills and very little on clinical teaching skills or evaluative skills. Karuhije (1986) recommmends, based on a survey of 211 nurse educators, that nursing graduate programs should seriously consider incorporating information on clinical instruction as they found that often clinical specialists who assumed faculty positions were unprepared to function effectively. The educators in this study were not asked to indicate or describe what their educational preparation had been, but the minimum educational requirement for a nursing instructor in the schools of nursing included in the study was that they possess a baccalaureate degree in nursing. Even in master's nursing programs there was a deficiency in clinical skills preparation. (Karns and Schwab,1982). Feldman (1986) suggests that supervisors must possess the necessary expertise for performance appraisal and that training programs are beneficial.

Comments by the participants indicating that they feel they reduced the influence of subjectivity by being more aware of their biases is in keeping with what Schneier, Beatty and Baird (1986) recommend. They suggest that they manner in which raters process and judge information about a ratee's behavior may affect the performance rating more than the actual performance.

Generally, providing students verbal and written feedback regarding their progress is encouraged in the literature especially in regards to the prevention of appeals and legal battles. Neidringhaus and O'Driscoll (1983) suggest that observations and situations should be shared between instructor and student so that the student has the opportunity to discuss, explain and clarify the events. This action reduces the risk of misunderstandings developing between the student and educator. Attempts to establish a climate of open communication and mutual trust during verbal feedback between educator and student are supported by Lancaster (1985) in the literature. She emphasized that performance is improved in an unthreatening environment which is enhanced by frequent instructor-student interaction.

Another purpose of verbal feedback was to communicate to a student that it is the educator's responsibility to assess every student's level of performance or behavior in the clinical setting especially in regards to patient safety. Often the educators seemed defensive that their presence with a student caused anxiety in the student and apparently decreased their proficiency. One must remember that it is the responsibility of the instructor to ensure the student is performing at a safe competent level. However, the educator must communicate this message to students.

Overall, the strategy of giving written feedback was reported to be quite varied with the participants of this study. It would seem that the intention to reduce subjectivity and clarify assessments and expectations were the general rationale for this strategy. The literature reviewed indicated that written documentation is an important strategy in clinical evaluation, but for different reasons. Fowler and Heater (1983) and Wood (1985) stress the need for educators to keep thorough and accurate documentation of a student's progress, and to discuss this frequently with the students specifically to clarify and increase communication to reduce the frequency of litigation and student appeals. The strategy, regardless of intent, can increase instructor-student awareness of the student's progress and gives both parties an opportunity to express their perceptions and intentions.

The utilization of an additional instructor is a strategy is supported by the literature but often is not practised in nursing due to the intimacy of the nurse-patient relationship. Pervin (1984) suggests the use of evaluator teams to reduce rater error. A few of the instructors in the study worked in a nursing school where a second instructor is available for consultation or actual observer assistance. They seem to have an advantage over educators in other institutions were this is unavailable. Some schools frown upon this strategy as indicative of a lack of confidence in the evaluating instructors judgements. Generally, discussion regarding a student's assessment is held in confidence between two or three peers and not formally acknowledged or encouraged.

In conclusion, the educators in the study throughout the interviews acknowledged that subjectivity was present and that it likely could not be totally overcome, but all expressed a concern regarding the need to be fair when evaluating student performance and progress. Schneier, Beatty and Baird (1986) and Forbes (1979) indicate that evaluation is a great challenge and human judgements are subjective, no matter how well-meaning a rater may be.

The conscious efforts by these instructors to recognize their biases should be considered honorable when remembering that the writers reviewed from the literature generally accepted subjectivity as inevitable.

CHAPTER VI

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the summary of the findings of this study, conclusions of those findings and recommendations for future research.

Summary of the Study

This study was undertaken to explore perceptions of nursing educators regarding subjectivity in the clinical evaluation process. Clinical evaluation of nursing students poses difficulties for clinical instructors in many ways. Research data were collected from eight educators in three diploma nursing schools in Edmonton. Each participant was interviewed twice; three research question were probed during each interview. The first interview was held at the beginning of the 1989 spring term of clinical experience and the second interview took place at the end of that term following evaluation of the nursing students. For most of the instructors and students the evaluation marked the end of the clinical rotation, but for some, the evaluation was a midterm point and they would resume the clinical course in the autumn of the year. Because all the instructors in the study were actively involved in clinical teaching and evaluation during the time of the study, it was expected by the researcher that the perceptions and ideas expressed would be related to their current students and experiences.

The responses from the instructors in this study were freely and openly offered. Perceptions and comments were made that indicated subjectivity was part of clinical evaluation. Some participants described biases and preferences that affected their judgements and assessments of students. Some indicated a desire to change, and others stated they probably could not change certain personal values held as important in their role as educators.

Summary and discussion of this study will be arranged by the three research questions. The responses of the participants to the research questions from both interviews will be summarized simultaneously.

Research Question One

The first research question, what part does subjectivity play in the clinical evaluation of nursing students, was asked to explore instructor's perceptions, ideas and experiences related to subjectivity in the clinical evaluation process of nursing students. Participants reported numerous issues they felt influenced a student's evaluation, although most of the issues discussed were ones that a student has minimal or no control over.

Table 8 lists the topics which were discussed by the respondents in the study. The frequency of responses is noted in decreasing total frequency for both interviews. Also listed is the frequency of responses for each interview.

Table 8

Distribution of Total Comments Regarding Factors Influencing Subjectivity in Clinical Evaluation

Topic	Interview 1 N = 8	Interview 2 N = 8	Combined N =16
Presence of Subjectivity	8	8	16
Input from Others	5	6	11
Previous Evaluations	5	3	8
Instructor Experience	5	2	7
Patient Assignment	2	5	7
Interpretation of Objectives	6		6
Time with Student		6	6
Instructor Expectations	5		5
Interpretation of Objectives	5		5
Assignment of Grades		4	4
Observed Behavior	3		3
Fair Judgements		3	3
Timing of Evaluation	2		2
Student Experiences		2	2
Non-clinical Responsibilities	1		1
Previous Instructors		1	1

As can be seen the three most frequently discussed themes during the interviews relating to question one were presence of subjectivity in clinical evaluation, input from others, and previous student evaluations.

All of the respondents in the study commented on the presence of subjectivity in the clinical evaluations process in each of the interviews. An indication from this study is that subjectivity did indeed influence instructor's decisions and judgements when evaluating nursing students. The majority of the respondents stated they felt subjectivity entered the evaluation process as soon as they allowed their feelings to affect their judgements.

The most common theme from participant responses in the study when describing subjectivity was that subjectivity enters into the process of evaluation where interpretation begins. In contrast, the participants described objectivity as that which is limited to observable behavior plus what's heard, read or seen. These statements indicate instructors acknowledge a difference between subjectivity and objectivity. Since the clinical evaluation process requires an educator to judge a student's performance, it seems implicit from these comments that subjectivity is inevitable in clinical evaluation.

All of the participants reported they could not avoid developing feelings and impressions when working with and evaluating students. Reasons given for this inevitable subjectivity in clinical evaluation included being human, having personal values and biases, having preferences and being individuals. Overall the respondents felt it would be impossible to remove subjectivity from the process of clinical evaluation.

The second most frequently discussed topic by the instructors in the study regarding question one was the influence input from others had on subjectivity in clinical evaluation. Instructors reported they received comments from staff and patients on the clinical units plus from other instructors. The respondents reported they sometimes would not include these outside comments in a student's evaluation because often they felt the comments were very biased, overly generous, unfair, or given by persons with negative feelings for all students generally. However, the educators acknowledged that even when they did not consider or act on the comments, the fact they had heard the comments caused them to think more about the student, thus subjectivity was increased.

The overall impression from the participants in the study was that it was undesirable to read a student's previous evaluations, at least until the instructor had worked with the student for a period of time. The one instructor who reported she read student's previous evaluations prior to working with the students, stated felt she trusted the integrity and honesty of her peers, and thus did not feel reading previous evaluations increased her subjectivity.

Research Question Two

The second research question explored in this study was: What characteristics and behaviors of nursing students do instructors perceive as influencing factors on their subjectivity in the clinical evaluation process? During the first interview with each participant, numerous student behaviors and characteristics were discussed. The instructors were very candid about their opinions and biases providing detailed examples in some instances. The discussion of this question was much briefer in the second interviews.

Table 9 lists the issues discussed by the participants during both interviews in this study regarding question two. The frequency of responses for each interview as well as a combined total of responses are illustrated.

The most common issue pertaining to the second research question which emerged from all the interviews was student behaviors regarding self expression. As shown in Table 9, by decreasing frequency, three issues were then discussed equally. These characteristics or behaviors were: first impressions, personal traits and gender of the student. All of these topics were discussed during the first interviews by the participants but for no apparent reason, not one instructor chose to discuss these issues during the second interviews.

In general, respondents stated they had concerns and felt some biases regarding student behaviors of self expression which they felt could influence their evaluations. The preferences indicated the most were that a student should be able to verbally express their needs and opinions in a polite yet assertive way. Any signs of aggressive behavior were deemed undesirable.

Table 9

Distribution of Total Comments Regarding Student Characteristics and Behaviors Affecting Subjectivity

Issue	Interview 1 N = 8	Interview 2 N = 8	Combined N =16
Self Expression	7		7
First Impressions	5		5
Personal Traits	5		5
Gender	5		5
Responsibility	2	2	4
Ethnicity	4		4
Personality	4		4
Anxiety	4		4
Caring	4		4
Age	4		4
Maturity	3		3
Physical Characteristics	3		3
Facial Expressions	3		3
Voice and Speech	3		3
Student interaction		3	3
Initiative and Interest	2		2
Patient teaching		2	2
Speed of Performance		2	2
Appearance		2	2

It seems that most of these instructors valued their first impressions of students even when the first encounter was out of the clinical setting. Also significant were characteristics and behaviors such as being an unenthusiastic, poorly groomed, or tardy. Though behaviors were not directly related to clinical performance and abilities, they resulted in unfavorable perceptions by the evaluators. Characteristics and behaviors such as these were considered to generally increase negative subjectivity on the student's clinical evaluation. The reverse behaviors lead to a positive influence.

Research Question Three

The third research question explored in this study was: How do instructors deal with subjectivity in clinical evaluation of nursing students? Sixteen strategies utilized when dealing with subjectivity were discussed by the eight participants during the study. Eight strategies were discussed in both interviews, five strategies were discussed only in the first interviews, while during the second interviews, six strategies were discussed by the participants that had not been reported in the first interviews. The collection of additional data in the second interviews reinforces the value of both interviews in the study.

Table 10 lists, in decreasing frequency, the strategies reported by the instructors in both interviews. The two most common strategies discussed by the participants were the awareness of subjectivity and verbal feedback to students. These topics were discussed by all of the participants in the second interviews, some of whom had discussed the topics in the earlier interview as well. As seen in Table 10, fourteen other strategies were discussed by fewer respondents throughout the interviews.

Table 10

Distribution of Total Comments Regarding Strategies Utilized when Dealing with Subjectivity

Strategy	Interview 1 N = 8	Interview 2 N = 8	Combined N = 16
Awareness of Subjectivity	5	8	13
Verbal Feedback to Students	2	8	10
Additional Instructor Input	2	4	6
Written Feedback to Students		6	6
Self Evaluation	3	2	5
Collect Additional Data		4	4
Assignment Selection		3	3
Data - Objective Comparison	2		2
Skills Checklist	2		2
Objective Terminology	2		2
Student - Instructor Evaluation		2	2
Think more about Student		2	2
Point System	1		1
Student Comparison	1		1
Avoid Acknowledging Subjectivity		1	1

Awareness of subjectivity was reported by the participants to be a major factor in decreasing their subjectivity in clinical evaluation. All respondents stated that as their awareness of subjectivity increased, they felt their subjectivity decreased. Thinking about biases and becoming aware of biases were important steps for these instructors when dealing with subjectivity. Many of the educators stated they did not feel the assessment of a student could ever be totally free of subjectivity due to the human elements involved in the process, but they indicated that increased awareness of subjectivity helped reduce its influence.

It would seem that if all of these educators are certain that awareness of subjectivity is an important step in reducing the influence of subjectivity, then this is likely a valuable strategy for other instructors to utilize.

Verbal feedback to students was a strategy all participants reported they used frequently with students in attempting to reduce the influence of subjectivity in clinical evaluation. The use of verbal feedback was used as a strategy varied among the educators. Most stated they would verify with a student their perceptions and impressions of a performance especially if errors had been observed. Many reported they gave verbal feedback to a student immediately after observing a performance. Negative feedback to students was reported to be a difficult task by instructors with limited experience as nurse educators. Several participants indicated the time spent giving verbal feedback to students was not only valuable in reducing subjectivity but also valuable because it gave students a time to talk with the educator. Subjectivity in clinical evaluation was felt by the respondents to be decreased by this strategy because the rater had the opportunity to verify observations and assessments with the student thus, reducing the inclusion of biases and misinterpretations into the performance appraisal.

Conclusions of the Study

The focus of this study was the perceptions of nursing instructors regarding subjectivity in the clinical evaluation process. Participants discussed numerous issues they had experienced during contact with students which they felt affected their subjectivity and thus influenced the clinical evaluations they had developed. Based on the discussion by the participants in the study, it can be concluded that:

1. Subjectivity in evaluation is both complex and inevitable. Nursing instructors are concerned about the assessments they develop regarding students and the influence subjectivity has upon their judgements. Most, still willingly accept that some subjectivity is inevitable.

When instructors take time to think about subjectivity, they recognize subjectivity is influenced by many factors including their their past experiences and expectations, input from others, timeliness as well as varied student behaviors and characteristics. Even though many of these factors are not within a student's control they continue to exert a influence upon an evaluator's subjective judgements thus affecting a student's performance appraisal.

2. Awareness of subjectivity in clinical evaluation is the first step in reducing its influence. This begins when evaluators

become conscious of their biases, values and opinions. As reported in the study various strategies can be utilized to control the influence of subjectivity in performance appraisal. It is considered desirable to reduce the influence subjectivity has upon the clinical evaluation process in nursing education.

As clinical instructors gained more experience with evaluation, they verified their perceptions through student feedback, verbally and in writing, and more carefully watched for possible inclusion of subjectivity in their assessments. The experienced clinical instructor was more focused on the performance rather than on the distractions surrounding the student's performance.

3. The level of instructor confidence to accurately evaluate nursing students in clinical situations seemed to at times to be questioned by the participants themselves. Generally, the educators in this study implied that their formal educational preparation had included minimal content regarding the process of clinical evaluation. Had they been more formally prepared they could have had more confidence in their abilities regarding clinical evaluation. Schneier, Beatty and Baird (1986) state that a way to ensure success in performance appraisal is to provide rater training and practice.

Generally the instructors reported they found performance appraisals were difficult to develop and consumed a considerable amount of time. Giving feedback to students of a negative nature was especially difficult for the less experienced instructors.

4. Overall, nursing educators are interested in controlling the influence subjectivity has on the clinical evaluation process to ensure fair and accurate performance appraisal of a student's clinical performance. Instructors acknowledged that the presence of subjectivity was inevitable but they indicated they wished to reduced any negative influence their biases might have on a student's clinical evaluation.

The educators were aware of the long term effects evaluations could have on a student's progression through a nursing program and took seriously their responsibilities in developing fair and accurate clinical evaluations.

Recommendations

Based on the findings of this research, the following recommendations for further research and practice are offered.

1. A quantitative study utilizing the findings of this study to formulate a questionnaire, be conducted utilizing a larger population and demographic factors on the topic of instructor perceptions of subjectivity in clinical evaluation of nursing students.

As this was an exploratory study, its findings should be used to establish follow-up research to further expand the information base in nursing education regarding the clinical evaluation process.

2. A continuing education workshop be developed to educate nursing instructors about subjectivity in clinical evaluation.

Factors influencing subjective judgements, recognizing areas of bias, and strategies to work with and reduce subjectivity in clinical evaluation of nursing students should be included in the workshop.

The literature reviewed and the findings of this study indicate that educators in nursing education could benefit from continuing education in the realm of clinical teaching including performance evaluation.

3. A course regarding clinical evaluation should be included in the curriculum of educational programs which prepare nurse educators for clinical teaching and evaluation of nursing students.

The findings of this study support what is found in the literature indicating that the educational preparation of clinical instructors generally seems to be deficient in the development of expertise in clinical evaluation. Graduate programs in nursing have traditionally not focused on the practical skills including performance appraisal that nursing educators require for their role as nurse educators in nursing education.

4. A replication of this study should be conducted to determine if other nursing instructors, in Edmonton or other cities, would demonstrate similar concerns and opinions. This would assist in the validation of these findings.

Closing Statements

This exploratory study was undertaken to discovery what nursing educators thought regarding subjectivity in clinical evaluation of nursing students. The response received from the participants regarding the study was encouraging. These educators took their responsibility in developing fair performance appraisals for each student seriously. Each instructor expressed concern they might have at one time or another possibly erred in their judgements, due to subjectivity. All agreed there would always be some subjectivity in clinical evaluation but they expressed a desire to control the overall effect instructor subjectivity might have on a student's evaluation and/or career.

One impression I developed during this study was that the participants were evaluating students in the clinical setting based on personal experiences, learned skills, trial and error techniques, and suggestions from colleagues. The intentions of the educators were sincere, but generally they did not seem to be operating from a foundation of formal education or research supported theories. I feel this apparent lack of preparation in clinical evaluative skills leaves the nursing instructor at a disadvantage and in a vulnerable situation. This study, in conjunction with previous research, emphasizes the need for clinical instructors to be appropriately educated to deal with the challenges of clinical teaching.

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Appendix A

April 18, 1989

Instructor, Diploma Nursing Program

Dear Instructor,

RE: THESIS RESEARCH: MASTER'S IN ADULT AND HIGHER EDUCATION

Have you ever thought about if, and how, subjectivity affects the process of clinical evaluation of nursing students? I would like to have your cooperation and participation in my upcoming research endeavor which will complete the work required for my Master's Degree in Adult and Higher Education. The title of my thesis is "Instructor Perceptions of Subjectivity in Clinical Evaluation". It is an exploratory study which will look at instructor's perceptions of subjectivity in the process of evaluating nursing students in the clinical environment. The purpose of the study is to derive some idea of what clinical instructors perceive to be subjectivity and how they feel it affects the process of evaluating the nursing student in the clinical environment.

Your involvement will consist of two semi-structured interviews with me, during which your comments regarding your perceptions and views of subjectivity in the clinical evaluation process will be elicited. Your involvement is voluntary and you are under no obligation to participate. Your participation in the study will of course be kept confidential by this researcher. Research reporting will be achieved by use of pseudonyms.

The interviews will be held at mutually agreed times, however the first interviews hopefully will be held in the first few weeks of May. The second interview will follow in the later part of June or early July 1989. Each interview will likely take approximately one hour. Your permission will be sought to allow the interviews to be taped, in order to facilitate open dialogue and more reliable data review. Transcribes of your interviews will be available to you upon request, but no one else, except this researcher will have access to the tapes. The tapes will be destroyed at the completion of this research study.

I strongly urge you to consider volunteering for this study. I have found the idea very intriguing and hope that you share my enthusiasm for the topic. I am quite excited at the prospect of commencing the interviews and collecting all of your ideas and perceptions regarding subjectivity in the process of clinical evaluation.

Please feel free to call me at my home phone number 464-4780 anytime after April 30 if you have any inquires, even if you are not certain that you wish to volunteer. If you are sure that you would like to take part in this research, you can simply complete and return the attached form. I will contact you in the first week of May.

Your time and cooperation are greatly appreciated. If you have any questions regarding this study, please call me at 464-4780 after April 30. I will be away until then on a brief family vacation.

Yours truly,

Ruth Stewart

Appendix B

STUDY: PERCEPTIONS OF SUBJECTIVITY

I am interested in participating in the research study on "Instructor Perceptions of Subjectivity in Clinical Evaluation."

YES __________ NO __________

I MIGHT CONSIDER PARTICIPATING IN THIS STUDY BUT WOULD LIKE TO HAVE MORE INFORMATION REGARDING THIS STUDY BEFORE I DECIDE.

YES __________ NO __________

Are you currently working with a group of students that you will be evaluating clinically?

YES __________ NO __________

NAME____

ADDRESS____
____
____

PHONE____

Is there a time of day that is more convenient for you to be contacted? Please specify ______________

Thank you for your cooperation and time. I will be contacting you very soon.

Appendix C

CONSENT FOR INTERVIEW TAPING

STUDY "INSTRUCTOR PERCEPTIONS OF SUBJECTIVITY IN CLINICAL EVALUATION"

Researcher - Ruth Stewart

Study Purpose - Thesis Requirement towards a
Master's Degree in Adult and Higher Education

I freely and willingly give consent to have this interview with Ruth Stewart taped electronically for the sole purposes of the above mentioned study. I will have access to the transcript upon my request. I am aware that the tapes will be erased after the entire study and reporting have been completed. Transcript reporting will use pseudonyms.

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DATE___________________________